



INSTITUTE FOR CLINICAL SYSTEMS IMPROVEMENT

Task 2

Report on the Current “State of the Art” for Medical / Health Care Home

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State of the art:

“The highest level of development . . . of a device, technique, or scientific field, achieved at a particular time . . . usually as a result of modern methods.” (Wikipedia)

“The most recent, and therefore considered the best; up-to-the-minute.” (Collins Essential Dictionary)

Background. The state of the art in “health care home” is of course linked to its particular time in history and development. Although there has been a flurry of interest and work around “medical home” recently, the concept has been around for at least 40 years. Sia et al (2004), in a history of the medical home concept, report the first documented use of the term “medical home” in Standards of Child Health Care, a book published by the American Academy of Pediatrics (AAP) in 1967 that emphasized having a central location for a child’s pediatric records, and contains this quote:

“For children with chronic diseases or disabling conditions, the lack of a complete record and a ‘medical home’ is a major deterrent to adequate health supervision. Wherever the child is cared for, the question should be asked, ‘Where is the child’s medical home?’ and any pertinent information should be transmitted to that place”.

Since the 1970’s, increasingly organized clinical and policy work aimed at reducing the fragmentation of care among independent providers in disparate locations has taken place—starting in pediatrics and then blending in similar efforts in family medicine and internal medicine. By March 2007, the American Academy of Family Physicians (AAFP), the American Academy of Pediatrics (AAP), the American College of Physicians (ACP), and the American Osteopathic Association (AOA) issued a joint statement of principles of the “Patient-Centered Medical Home”, thus bringing these disciplines together on goals and principles.

Medical home demonstration projects or criteria systems have been set up through NCQA, AAFP / TransforMED, and CMS (Medicare / Medicaid), supported by important literature reviews or evidence-based position papers.

Terminology has also evolved, with “health care home” introduced in North Carolina in the early 1980’s to make the concept more acceptable to policymakers (Sia et al, 2004). In 2006 the ACP policy monograph described “the advanced medical home” and later “patient-centered medical home” appeared in the joint statement of principles by AAFP, AAP, ACP, and AOA. Health care home is the term used by the Minnesota Departments of Health and of Human Services—as the broader and less medical- or provider-centric concept. All these terms share a great deal in common.

Maturity of the field. Even with a 40-year history, the state of the art in health care home is much more mature as a set of goals, principles, design concepts, pilot results and demonstration projects than as large-scale, repeatable implementations pointing to a single evidence-based “best practice”.

Best practice:

“A technique, method, process . . . more effective at delivering a particular outcome than any other, with fewer problems and unforeseen complications . . . the most efficient and effective way of accomplishing a task, based on repeatable procedures. . . proven over time for large numbers of people” (a general definition from Wikipedia)

The field of “health care home” may not yet be mature enough to yield decisive *best* practices, but is certainly mature enough to yield a coherent set of *promising* practices and engaging demonstrations.

The task: The purpose of this report is therefore to provide a practical overview or inventory of:

1. A sample of work being done nationally around health care homes—in descriptive terms that show common themes and significant differences
2. A sample of work being done in Minnesota on health care homes—showing common themes and significant differences.
3. Promising models drawn from the literature to help set realistic timeframes for development of health care homes at a level of maturity that can reasonably be expected to achieve the ultimate outcomes people desire from health care homes.

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Part I: An inventory of work being done nationally. This has two parts:

1. A meaningful but manageable sample of major national work in the area of Medical Home
2. A narrative distillation or summary of current state of the art from these papers—a snapshot of common themes and significant differences.

1. A meaningful but manageable sample of major national work in the area of Medical Home.

This is a core body of very recent review articles, evidence-based white papers, and criteria or demonstration project papers that capture most of the major literature along with conclusions and recommendations. This body of thought, evidence, experience and opinion is regarded here as a manageable source from which to create a snapshot of the current state of the art. *The papers below comprise this sample and are summarized, paraphrased, or abstracted in an attachment.*

Literature-based position papers or consensus statements

- Joint Principles for Patient-Centered Medical Home; AAFP, AAP, ACP, AOA (3/07)
- Commonwealth Fund: Organizing US care delivery for high performance (8/08)
- National Quality Forum—National Priorities Partnership. National Priorities and Goals: Aligning Our Efforts to Transform America’s Healthcare (11/08)
- Medical Home: Disruptive Innovation for a New Primary Care Model. Deloitte Center for Health Solutions (2008)
- The Patient-Centered Medical Home—A purchaser guide (2008). National Business Coalition on Health through grant from the Patient-Centered Primary Care Collaborative
- Behavioral Health / Primary Care Integration and the Person-Centered Healthcare Home—a discussion draft. National Council for Community Behavioral Healthcare (NCCBH, 10/08)

Literature reviews

- New York Primary Care Coalition Statement of Evidence-based Literature to Inform Health Policy (11/07)
- American Cancer Society Medical Home Model Review (3/07)

Standards and criteria for Health Care Homes

- NCQA standards and guidelines; PC-PCMH CMS version (10/08)
- AAFP / TransforMED Medical Home Model demonstration and components (11/08)
- CMS Medical Home demonstration design & qualifying criteria (10/08)

Demonstration projects

- Patient Centered Primary Care Collaborative (PCPCC) pilot projects (2008)
- State-sponsored demonstration projects (2008) and other demonstration projects

Recall that “state of the art” means “the highest level of development . . . achieved at a particular time. . . usually as a result of modern methods. . . the most recent, and therefore considered the best; up-to-the-minute.” The groups that authored these recent papers represent aggregate efforts of many of those seriously trying to design, evaluate, implement, and test health care home concepts from clinical, systems, financial, and policy perspectives “in real time” and at various levels of risk, and hence can be considered among the primary or at least most articulate sources of current “state of the art”.

Note that these papers tell the healthcare home story mostly from the perspective of providers, insurers, purchasers, or policy-oriented groups rather than specifically from the patient or citizen point of view. Although there is constant reference to patient engagement and the patient experience, there was no white paper written by patients and families from their perspective. At the same time there exist

many papers dealing more specifically with patient engagement, e.g. Institute for Family-Centered Care (2008) Center for Advancement of Health (2008)

These papers all contain literature reviews, using many of the same primary references. So rather than individually review the much larger body of primary references, this report employs these review and evidence-based position papers as the core source from which to distill a statement of the national state of the art. Of course there are other papers that could or perhaps should be added to this, and hopefully this will be regarded as an expandable document capable of incorporating new and updated source material as it comes in or becomes even more relevant to include here. In addition to these papers are abstracts of a large sample of private and public demonstration projects.

2. A narrative distillation or summary of current state of the art from these papers includes a snapshot of common themes and significant differences in:

- A. Goals for healthcare home
- B. Governing or operating principles invoked
- C. Functions, components, or criteria
- D. Outcomes demonstrated—patient, system, health, and financial

A. Goals for health care home

Common themes: A striking concordance in goals for medical home appears across the national literature. The following goal-related statements are common themes across the recent body of work surveyed. Hence this list can be considered the “state of the art” in goal articulation for health care home—“the national state of the art in healthcare home when it comes to what the goals are.”

Patient experience goals:

- The one place you can go to eventually connect with whatever you need
- Comprehensive and broad care—preventive and curative; all ages; biomedical and behavioral
- Long-term relationships with providers; continuity; healing relationships
- Partnerships between patients and physicians / teams; informed / shared decision-making
- Coordinated, integrated care that is easily navigated and not fragmented
- Satisfying experience
- Getting care that is needed—and when it is needed—not care you don’t need
- Safe care, not harmful care, reliably available
- More affordable care; scientifically valid care
- Care and relationships taking place in a culturally and linguistically appropriate manner

Health outcomes or goals:

- Improved chronic illness care across major diseases and conditions
- Better prevention / public health goals to reduce disease burden
- Better control of health problems at the source—patient self-management and responsibility

System outcomes or goals:

- Primary care that is more available to patients and attractive / satisfying to providers as a career
- System integration across diseases and populations, with “left hand knowing what right hand is doing”—a platform of comprehensive, coordinated care
- Reduced waste from inefficient systems and use of needless care, procedures, technology
- Increased safety—reduction of harmful care and errors

Financial outcomes or goals

- Reduced cost from system waste, fragmentation, or needless care
- Financial viability for practices
- Financial relief for purchasers
- Financial burden reduced for patient out of pocket and employee share.

Significant differences: While there is strong concordance on goals, these papers do not contain completely identical or equivalent goal statements. Significant differences exist in emphasis, importance, or frequency of appearance of the kinds of goals. Goal areas are where the national state of the art is not so clear:

- End-of-life care—to what extent modern end-of-life care is part of the health care home goal set—including palliative care and community / spiritual support.
- Behavioral health—to what extent behavioral health and mental health and substance abuse conditions are to be a visible part of the purpose and goal of healthcare homes and integrated with general medical care—or general medical care integrated with specialty behavioral health care in a “health care home” for patients with serious mental illness
- Connectivity to other parts of care continuum—to what extent the goal of health care homes is not only to be internally comprehensive and integrated but take responsibility for creating (or trying to create) highly integrated connectivity with the rest of the continuum of care, e.g., hospitals, rehab centers, transitional care, nursing homes, home care etc.
- Patient involvement in the practice (not just in their own health)—to what extent health care home goals includes transparency of practice operations, procedures, prices, and patient involvement in the philosophy, design, and customs or mutual expectations of the practice
- Health disparities—to what extent health care home goals include equalizing health disparities based on culture or language or socioeconomic status or presence of serious mental illness or other conditions that could interfere with usual care.

Goal-related language in the literature from which these themes were distilled: The foregoing common themes and significant differences in goal-related statements for health care home were distilled from scanning goal statements for health care home or primary care redesign. A sample of goal-related language taken from the national papers is shown here:

- . . . An approach to . . . comprehensive primary care for children, youth and adults—a health care setting that facilitates partnerships between individual patients, and their personal physicians, and when appropriate, the patient’s family”. (Joint principles, 2007)
- . . . To provide a patient with a broad spectrum of care, both preventive and curative, over a period of time and to coordinate all of the care the patient receives. (Deloitte Medical Home, 2008)
- . . . A personal medical home . . . through which all individuals. . . receive acute, chronic and preventive medical services. . . through ongoing relationship with a family physician . . . patients can be assured of care that is accessible . . . accountable, comprehensive, integrated, patient-centered, safe, scientifically valid, and satisfying to both patients and their physicians." (AAFP / TransforMED, 2006)
- . . . A health care setting that facilitates partnerships between individual patients, and their personal physicians . . . care facilitated by registries, information technology, health information exchange and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner. (NCQA, 2008)
- . . . The medical home . . . is expected to achieve. . . integration and coordination of health care by primary care physicians. . . to enhance patient adherence to recommended treatment . . . avoid hospitalizations, unnecessary office visits, tests, and procedures . . . and use of expensive technology . . . when less expensive tests or treatments are equally effective; and [reduce] patient safety risks inherent in inconsistent treatment decisions”. (CMS Medical Home Demonstration Design, 2008)
- . . . A point of access to health care organized around the patient’s needs and built on a relationship between a patient and a physician . . . a primary healthcare base providing 90% of health needs and coordinating specialty referrals, ancillary services. . . a source of first contact care and comprehensive care across a

continuum of preventive, acute and chronic health care needs. . . a place where they get to know you. (NY Medical Home Evidence Policy Statement, 2007)

- . . . Patients & families have continuity care founded on a long-term relationship with a provider and a provider team. . . Healthcare from perspective of the pt & family . . . integration of medical and behavioral services in general medical office. . . integrated bio-psycho-social view of medical home consistent with patient beliefs and . . . to enhance wellness and reduce costs (NY Medical Home Evidence Policy Statement, 2007)
- . . . Patients & families have continuity care founded on a long-term relationship with a provider and a provider team. . .health care from perspective of the pt & family. . . The patient and physician decide the specific health care objectives and best way to achieve them . . . with a team that may form and reform according to patient needs . . . integrates care of medical and behavioral needs in general medical office. (NY Medical Home Evidence Policy Statement, 2007)
- . . . Improved health outcomes, patient experience and lower costs in an environment in which patients make informed decisions about their treatment providing a platform for comprehensive coordinated care that is safe, affordable, and high quality. (American Cancer Society Medical Home Model Review (2007)
- . . . A system that guides patients and families through their healthcare experience while respecting patient choice, offering physical & psychological supports, and encouraging strong relationships between patients and healthcare professionals. . . offering voice, control, choice, skills in self-care, transparency; adapted to individual and family circumstances, cultures, languages and social backgrounds. . . systems of care invested in prevention of disease, injury, and disability. . . relentless in continually reducing risks of injury from care. . . absolutely reliable care. . . care promising dignity, comfort, companionship, and spiritual support to patients and families facing advanced illness or dying, with all the resources that community, friends, and family can bring to bear at the end of life. . . care that promotes better health and more affordable care by continually and safely reducing the burden of unscientific, inappropriate, and excessive care, including tests, drugs, procedures, visits, and hospital stays. (National Quality Forum, 11/08)
- . . . Healthcare for general, mental health, & substance-use problems with understanding of the inherent interactions between mind/brain and rest of the body. The aims, rules, and strategies for redesign in Quality Chasm to be applied throughout mental/substance use healthcare but tailored to characteristics that distinguish care for these problems and illnesses from general health care (NCCB Behavioral Health / Health Care Home discussion draft, 10/08)

Larger or more systemic national goals are also evident:

- . . . Address the crisis in primary care, e.g., primary care physician shortage and disillusionment, avoidable costs, and need for coordinated care & longitudinal healing relationships. (NCQA, 2008)
- . . . Reduce the characteristic fragmentation of care that is fundamental to poor care system performance and patient experience, provider satisfaction and waste and expense. (Commonwealth Fund, 2008)
- . . . Reduce the fragmentation of care for Medicare beneficiaries and its relationship to rapidly rising health care costs that are well documented (CMS Medical Home Demonstration, 2008)
- . . . Eliminate harm, eradicate health disparities, reduce disease burden, remove waste (National Quality Forum, 2008)
- . . . Address the burning platform of chronic illness care, primary care workforce shortage, and overall healthcare costs. (Deloitte Medical Home, 2008)
- . . . Increase evidence based care actually required, reduce care not required, harmful, or wasteful. . . reduce unnecessary costs to improve competitive position of employers who purchase healthcare and ease burden on employees. . . reverse the decline of primary care. . . take a chance on promising new ideas such as medical home rather than settle for the status quo. (The Patient-Centered Medical Home—A Purchaser’s Guide, 2008)

- . . . Signal the need for behavioral healthcare services in primary care settings. . .bring together developments in patient-centered medical home with evidence-based approaches to integration of primary care and behavioral health. . . show what a medical home looks like for those with serious mental illness. (Behavioral Health and Person Centered Medical Home, 2008)
- . . . Improve chronic disease management, preventive service delivery, acute illness care, mental health care, patient satisfaction, patient-centeredness, clinician and staff quality of life, practice processes, financial viability through Medical Home (AAFP / TransforMED, 2008)

B. Health care home operating principles—the national state of the art

Common themes—operating principles

The “Joint Principles of Patient-Centered Medical Home” (AAFP, AAP, ACP, AOA, 2007) is the common backbone upon which almost all the national papers and demonstration projects hang their components and criteria. As such, this statement of principles can be regarded as representing the national “state of the art”. Abbreviated here:

1. *Personal physician*. . . ongoing relationship. . . first contact, continuous and comprehensive. . .
2. *Physician directed medical practice*. . . leads team who collectively take responsibility for ongoing care. . .
3. *Whole person orientation*. . . providing for all the patient’s health care needs. . . appropriately arranging care with other professionals. . . care for all stages of life. . . acute, chronic, preventive, end of life. . .
4. *Care coordinated / integrated* across all elements of the complex care system. . . subspecialty, hospitals, home health, nursing homes, community. . . facilitated by registries, information technology. . . to get patients care when and where they need and want it in culturally and linguistically appropriate manner. . .
5. *Quality and safety*. . . support optimal, patient-centered outcomes. . . defined by care planning . . . driven by partnership between physicians, patients, family. . . evidence-based medicine and decision-support tools. . . continuous quality improvement. . . performance measurement. . . patients actively participate in decision-making. . . and quality improvement at practice. . . information technology to support care, performance measurement, patient education, and communication. . . voluntary practice recognition. . . to demonstrate capabilities to provide services consistent with medical home model. . .
6. *Enhanced access to care*. . . through systems such as open scheduling, expanded hours and new options for communication between patients, personal physician, practice staff.
7. *Payment appropriately recognizes added value*. . . care management outside the face-to-face visit. . . separate FFS for face-to-face. . . coordination of care within a practice and between consultants, ancillary providers, and community resources. . . adoption and use of health information technology. . . enhanced communication such as secure e-mail and telephone. . . remote monitoring of clinical data. . . recognize case mix differences. . . allow physicians to share in savings from care management in office. . . payments for measurable and continuous quality improvements.

Significant differences or variations in emphasis—operating principles

Although these operating principles comprise a common backbone, different papers or demonstration projects feature, emphasize, or develop different aspects of these principles. When taken together these variations in emphasis may represent enhancements to the general state of the art represented in the joint principles.

- “*Patient voice—patient journey*”. All papers and demonstrations talk about patient-centered engagement and participation in care and decision-making. Others, e.g., the National Quality Forum (2008) explicitly emphasize listening to “the patient voice” and “organizing around the patient journey” regarding the experience of care across the continuum of care for that person, not just for discrete episodes of care.
- *Public reporting*. All papers and demonstrations involve performance measurement, but some emphasize transparent public reporting more than others, e.g., National Quality Forum, 2008; PCPCC, 2008)

- *Professional education and change management.* All papers and demonstrations recognize the need to support providers and practices in changing to the medical home model, but some are more explicit about the kinds of training required, e.g., National Quality Forum, 2008; PCPCC, 2008). Others emphasize change management, leadership development, or learning collaboratives far more than others, e.g., NQF, 2008; PCPCC, 2008, AAFP / TransforMED, 2008.
- *Chronic Care Model.* Although improving chronic care is explicit or implicit in all papers and demonstrations, there are differences in how prominently medical home design features or is based on the Wagner Chronic Care or Planned Care Model.
- *Practice-based care management.* Care management, care coordination, or case management is prominently featured in all papers and demonstrations. However, differences in meaning between these three terms tend not to be spelled out, or how broadly care coordination is to take place across the continuum of care to include inpatient, nursing homes, rehab facilities, public health and community resources.
- *Behavioral health integration.* All papers and demonstrations discuss integration of care and usually mention medical and behavioral care. But some emphasize this far more than others, e.g., the use of the IMPACT model for care of depression in primary care as a template for behavioral health integration in primary care medical homes (NCCBH, 2008; DIAMOND Initiative in Minnesota)
- *Multi-stakeholder, multi-payer engagement.* All papers and demonstrations mention broad stakeholder engagement, but some are much more clear than others on just what this means and how collaborative processes or convening skills are deployed to make joint efforts across providers, payers, employers, patients, and government programs truly productive and successful.
- *Medical home practice recognition.* Almost all papers and demonstrations point to the need for practices to become truly capable of functioning as medical homes in order to reap the benefits, and most of these point to the NCQA PC-PCMH criteria tool. Others point to alternatives such as the AAFP / TransforMED criteria, the CMS Medical Home Demonstration criteria, health plan criteria, or the possibility of other consensus based tools. Different papers and programs are more explicit than others on the medical home criteria or certification tools and process.
- *Payment reform.* All papers and demonstrations point to payment reform that rewards primary care work beyond face-to-face visits or procedures, typically adding a bundled care management fee of some kind and some form of pay-for-performance bonus. While these are common themes, there are significant differences in payment model specifics or level of development.
- *Predictive modeling for case mix complexity or risk.* While payment reform is strongly featured in these papers and demonstrations, some emphasize predictive modeling for case mix or care management complexity as a factor in calculating care management payments.
- *Streamlined office processes and QI methods.* Most papers and demonstrations mention improved efficient office processes that reduce waste and create a better experience for patients and routine use of quality improvement methods, but different papers or demonstrations emphasize or feature this to different degrees.

Principle-related language in the papers and demonstrations. The common themes and differences distilled above can be seen while scanning a sample of operating principle statements from the various papers and demonstrations:

- . . . Clinical information available to all providers and patients at point of care through EHR. . . care coordinated among multiple providers. . . transitions across care settings actively managed. . . providers across settings accountable to each other for total care of patients, review each other's work, collaborate. . . easy patient access to care and information, including after hours. . . multiple points of entry. . . providers are culturally competent. . . system is continuously innovating to improve the quality, value and patients' experiences of health care delivery. (Commonwealth Fund, 2008)
- . . . Drivers of transformation are. . . performance measurement across settings, balancing QI with stability to track over time. . . public reporting meaningful to consumers, diverse goals based on national standards. . .

payment systems not tied to volume only, supporting coordination & integration, right incentives for patients. . . research & knowledge dissemination—particularly translational. . . professional development—patient-centered care, teams, EBM, QI methods, informatics. . . system capacity—away from fragmented and dysfunctional to HIT, care process design, interdisciplinary teams, coordination across diseases and settings. . . listening to patients and families—“patient voice” regarding experience of care. . . organizing around the patient’s journey. . . focus on continuum of care, not just individual performance. . . outcomes desired by pts . . . engage all stakeholders—patients and all providers. . . (National Quality Forum, 2008)

. . . A “medical home” is not a house, hospital or other building. . . a health care model in which persons use PC practices as basis for accessible, continuous, comprehensive, integrated care. . . an extension of the Wagner chronic care model. . . embraces joint principles for medical home. . . care management in the PC clinic, and personal physician rather than through distant care or disease mgmt entities and staff. . . (Deloitte, 2008)

. . . The Joint principles of the Patient-Centered Medical Home. . . Wagner Care Model. . . care coordination / case management as a proactive PC practice-based function done by members of the PC team and often not by a physician. . . employer / purchaser involvement in healthcare redesign. . . (PCPCC, 2008)

. . . Anchored in Joint Principles of the Patient Centered Medical Home. . . anchored in core components of IMPACT model for treating depression in PC and research on delivering primary care services in behavioral health settings and behavioral health in primary care settings. . . care manager embedded in the clinical team unlike disease mgmt models by phone from distant places or health plans. . . partnership between primary care and behavioral health providers . . . a population-based planning model for clinical integration of physical and behavioral health needs / risks. . . (NCCBH, 2008)

. . . The six aims and new rules of the 2001 IOM Crossing Quality Chasm report. . . patient has a usual source of healthcare. . . shared decision-making responsibility with patient and provider. . . personalized care coordination. . . access beyond acute care episode. . . identification of medical and community resources. . . care for all stages of life: acute, chronic, preventive, end-of-life. . . coordinated information to others involved in care (American Cancer Society, 2007)

. . . The joint principles for medical home. . . recognize physician practices that use systematic, patient-centered, coordinated care management processes. . . using specific measurable elements (NCQA, 2008)

. . . The joint principles of medical home. . . a continuous relationship with a personal physician coordinating care for both wellness and illness. . . with measurable medical home criteria. . . clinic-based leadership—locally shared vision, visible leadership, team development, change acceleration, project management, fostering a culture of improvement, enjoy and celebrate along the way (AAFP / TransforMED, 2008)

. . . The joint principles of medical home. . . integration and coordination of care by primary care physicians. . . to enhance patient adherence to treatment. . . and reduce fragmentation. . . with measurable medical home qualifying criteria (CMS Medical Home Demonstration Design, 2008)

. . . Collaboration and leadership—input from all relevant stakeholders. . . practice recognition—NCQA PCMH or similar recognition process for attributes in the Joint Principles. . . clear responsibilities of all parties, including providers, payers, patient/families. . . practice support to at least cover costs of PCMH recognition process, physician and staff work associated with project, practice infrastructure required for PCMH care model. . . maximizes number of patients in each participating practice. . . reimbursement model—prospective bundled component, visit-based fee component, performance-based component, recognize differences in patient case mix/complexity. . . assessment and reporting of results, public dissemination of results. . . (Guidelines for PCPCC Patient Centered Medical Home Demonstration Projects, 2008; www.pcpcc.net)

. . . Medicaid adoption of medical home. . . state legislative tracking and report out. . . engaged public sector purchasers. . . PCMH model systematized as the healthcare infrastructure. . . technical assistance and sharing best practices of PCMH. . . (PCPCC Center to Promote Public Payer Demonstration, 2008; www.pcpcc.net)

- . . . Improving care coordination and optimizing health status for each person. . . 24/7 PC and specialty access. . . nurse care coordinator in each site. . . predictive analysis to identify risk trends. . . virtual care management support. . . personal care navigator. . . EHR access to pts, providers, care mgrs—lab results, self-scheduling, secure email, EHR-based “snapshot reports” on single screen. . . chronic disease care optimization—to embed automatic, standard care workflows and delegate tasks. . . acute-episode care for CABG and other. . . (Geisinger Health System care model redesign, 2008)
- . . . Sickest and costliest patients to “opt in” to medical home model. . . focusing on team health care and linkage of specialists. . . at heart is dedicated physician & nurse with 24/7 access via email, phone, home visits. . . intensive care management—high tech, high-touch proactive care to identify and coordinate medical needs early and support change in patient behavior. . . (Boeing Ambulatory Intensive Care Unit, 2007)

C. Health care home components and performance criteria

Common themes in the state of the art medical home components and criteria

As would be expected, the operating principles described earlier overlap considerably with, or are embodied by, the components and criteria. In many cases, the components are associated with performance expectations or criteria such as the NCQA PC-PCMH criteria tool, the AAFP / TransforMED components, or the CMS Medical Home qualifying criteria. If the common core of components is boiled down across the papers and demonstrations here is what results:

1. *Practice-based care management.*

The state of the art in care management has yet to be spelled out more specifically, but incorporating care management is clearly required in the state of the art. The current papers and demonstrations range from care management for important conditions or populations to care management for complex cases to a more general approach to care management including for preventive care. They also range from a function performed by a member of the care team to a new care manager figure built into the care team. It also ranges in scope from managing care primarily within the practice to managing care for continuity across the different venues for care such as hospitals, specialties, nursing homes, physical therapy, behavioral health, etc.

2. *Practice-based team care*

The state of the art recognizes that the medical home model, especially for chronic care is a team-based rather than individual physician activity that calls for local leadership, shared mission, effective communication, appropriate division of labor and scope of practice, and of course patient participation on the team and as someone who accepts the team-based nature of medical home practice. The papers and demonstrations reveal a wide range of depth on specifically how teams are structured or managed, but in general they are seen as physician led (at least led clinically), and involve a care management figure, clinic staff, and specialists as needed. Extended teams are sometimes mentioned in the context of broader care management across sites or episodes.

3. *Patient access and communication processes.*

These include visits, scheduling, and phone access at the very least, to secure email communication, interactive websites, and personal health information portal. Shared clinician-patient decision-making is also featured—sometimes as part of communication processes and other times as part of self-management support.

4. *Patient tracking and registry functions.*

These are for individual and population health management and organizing clinical data in a way that can be used readily in practice-based care management. Whether tracking is condition-based, person-based, population-based or some combination is variable.

5. *Patient self-management support.*

This includes but goes far beyond patient education to include specific clinician-patient or staff-patient conversations on goal-setting and coaching, shared clinician-patient decision making, and connection to

community and family resources—along with documented plans and objectives than can be routinely followed and adjusted.

6. *Electronic health information technology.*

This includes EHR and related tools for purposes such as electronic prescribing, automated reminders and decision support, referral tracking, registries, patient portals for their own health information, and enhanced communication systems. Health information technology is seen as a backbone for several such components—including the broad goal of patient safety—although recognition is given that not all practices currently have mature electronic systems or can easily make those investments.

7. *Performance reporting*

Routine feedback of results and performance is a featured component or criteria in all models. The purpose ranges from routine and short-term quality feedback and improvement for internal use or in a learning collaborative, to longer-term tracking of results of evolving redesign, to establishing continued qualification as a medical home or payments. Different degrees of emphasis are given to public (vs. internal) reporting, although these sources suggest that public reporting of performance is part of the state of the art.

Significant differences in components or criteria. As with the operating principles, there are differences apparent in approach or emphasis to medical home components and criteria.

1. *Paradigm for care management.*

As mentioned above, everyone features care management as a central function and criteria, but there is some variation on how care management is focused, e.g., on a few important conditions, certain populations, certain level of severity, risk, or complexity, all conditions, or on a more person-centered rather than disease-centered basis.

2. *Behavioral health professionals routinely on care team?*

Most statements of principles call for care or care coordination over a range of biomedical and behavioral factors, but only a few models or demonstrations include behavioral health professionals as a built-in routine part of the on-site primary care team.

3. *Leadership / change management / culture change*

Some models, e.g., AAFP/ TransforMED and PCPCC include explicit practice management, change management, leadership functions, or learning collaboratives as part of medical home components or criteria. These are enabling functions, so that medical home can actually be implemented and cultural and operational adjustments made to become sustainable. Others appear to assume such functions are in the background but may not list them as functions or criteria.

4. *Medical home criteria sets or tools*

While the three criteria sets or tools featured in this review are getting at mostly the same things, they are saying them in different ways, organizing them differently, and contain somewhat different emphases. At this point the NCQA PC-PCMH as featured in many papers and demonstrations is the closest thing to being a standard. But the other criteria sets have their own supporters and the NCQA set is not without some objections, such as whether it is too operational and adequately addresses behavioral and psychosocial issues, the details of care management, orientation to practice as a team and who leads them, and shared patient-clinician decision-making (PC-PCC Purchasers guide, 2008). While most people will see that NCQA PC-PCMH is approaching becoming a standard, not everyone will agree it represents the state of the art.

Table of comparisons between criteria and component sets. Many of the common themes and differences mentioned above can be seen from this table of comparisons between the 3 major criteria/component sets of this review.

| NCQA PC-PCMH criteria | CMS Medical Home qualifying criteria | AAFP/ TransformMED components |
|---|---|---|
| <p>Standard 1. <u>Pt. Access & Communication</u> A. Access and communication processes B. Access and Communication Results C. Giving patient information on role of medical home</p> <p>Standard 2. <u>Patient tracking & registry functions</u> A. Basic system for managing patient data B. Electronic system for clinical data D. Organizing clinical data E. Identifying important conditions F. Use of system for population management G. Comprehensive health assessment</p> <p>Standard 3. <u>Care management</u> A. Guidelines for important conditions B. Preventive service clinician reminders C. Practice organization D. Care management for important conditions E. Continuity of Care</p> <p>Standard 4. <u>Patient self-mgmt support</u> A. Documenting communication needs B. Self-management support</p> <p>Standard 5. <u>Electronic prescribing</u> A. Electronic prescription writing B. Prescribing decision support--safety C. Prescribing decision support--efficiency</p> <p>Standard 6. <u>Test tracking</u> A. Test tracking and follow-up</p> <p>Standard 7. <u>Referral tracking</u> A. Referral tracking and coordination</p> <p>Standard 8. <u>Performance reporting</u> A. Measures of performance B. Patient experience data C. Reporting to physicians D. Setting goals and taking action</p> <p>Standard 9. <u>Advanced e-communication</u> A. Availability of interactive web site</p> | <p><u>Continuity</u> 1) Info on the role of the medical home 2) Standards on scheduling with clinician</p> <p><u>Clinical Information Systems</u> 3) Searchable data on demographics, visit dates, diagnoses, important conditions or risk factors; certified EHR.</p> <p><u>Delivery System Redesign</u> 4) Access standards: visits, phone, e-comm 5) Data on meeting access standards above 6) Roles for physician / non-physician staff 7) Electronic or paper tools such as med lists, problem lists, templates 8) Health assessment for all new pts 9) For 3 important conditions, conduct care mgmt / integrated care plan 10) For 3 important conditions, conduct previsit care mgmt and F/U after visit 11) Identify appropriate evidence-based guidelines as basis of care</p> <p><u>Patient/Family Engagement</u> 12) Patient/family self-mgmt from phys or non-physician staff 13) Educational resources; connecting families to self-management resources. 14) Family involvement</p> <p><u>Coordination</u> 15) Test tracking & F/U w patients 16) Referral coordination; reason, clinical findings, report back 17) The practice reviews all medications a patient is taking including prescriptions, over the counter medications and herbal therapies/supplements. 18) Inpatient or outpatient care coordination at transitions in care. 19) Post-hospital med list review, reconcile.</p> <p><i>And 3 of these additional 9 capabilities</i></p> <p><u>Clinical Information Systems</u> 20) Electronic prescribing 21) Patients/family interactive Web site 22) Patient access to personal health info</p> <p><u>Delivery System Redesign</u> 23) More performance data 24) Performance data reported to physicians 25) Performance data to set goals and action 26) Electronic info to remind patients or clinicians proactively of services needed 27) Paper or electronic system for reminders based on preventive guidelines 28) Paper or electronic system for reminders on guidelines for chronic care needs.</p> | <p><u>Access to Care & Information</u> • Same-day appointments • After-hours access coverage • Lab results highly accessible • Online patient services; e-Visits • Group visits • Culturally sensitive care</p> <p><u>Practice Services</u> • Care for both acute & chronic conditions • Prevention screening and services • Surgical procedures • Ancillary therapeutic, dx and support svcs</p> <p><u>Care Management</u> • Population management • Wellness promotion • Disease prevention • Chronic disease management • Care coordination • Patient engagement and education • Leverages automated technologies</p> <p><u>Continuity of Care Services</u> • Community-based services • Collaborative relationships: hospital, behavioral health, maternity, specialists, pharmacy, physical therapy, case mgmt</p> <p><u>Practice Management</u> • Disciplined financial management • Cost-Benefit decision-making • Revenue enhancement • Optimized coding & billing • Personnel/HR management • Facilities management • Optimized office design/redesign • Change management</p> <p><u>Health Information Technology</u> • EHR; electronic orders and reporting • Electronic prescribing • Evidence-based decision support • Population management registry • Practice web site; patient portal</p> <p><u>Quality and Safety</u> • Evidence-based best practices • Medication management • Patient satisfaction feedback • Clinical outcomes analysis • Quality improvement • Risk management • Regulatory compliance</p> <p><u>Practice-Based Team Care</u> • Provider leadership • Shared mission and vision • Effective communication • Task designation by skill set • Nurse Practitioner / Physician Assistant • Patient participation • Family involvement options</p> |

D. Health care home outcomes demonstrated—the state of the art

As said at the outset, “Health Care Home” is not a mature product or enterprise—with many pilot or demonstration projects in place but few if any full-scale, proven implementations with demonstrated outcomes on a meaningful scale. The state of the art will therefore represent not so much a short list of proven best practices, but a convergence of promising outcomes from many demonstrations at various levels of maturity—along with foundational research that gave medical home concepts credibility in the first place.

Foundational research comes in two areas: the benefits of a primary care practice orientation and findings from implementing components of the Chronic Care Model (paraphrased or quoted from PCPCC Purchaser’s guide, 2008).

Primary Care Practice Orientation. Barbara Starfield and others have researched the impact of a PC-oriented care system on outcomes, costs, and equity. Starfield has found that greater orientation towards PC results in lower costs and better outcomes. Conversely, a specialist-oriented system (like in U.S.) is associated with higher costs and poorer outcomes. Adequate access to primary care provides health and economic benefits (Phillips & Starfield, 2004)

- Reduced all-cause mortality & mortality by cardiovascular & pulmonary diseases
- Less use of emergency departments and hospitals
- Better preventive care
- Better detection of breast CA; reduced incidence & mortality from colon & cervical CA
- Fewer tests, higher patient satisfaction, less medication use, and lower care-related costs
- Reduced health disparities, particularly for areas with highest income inequality, including improved vision, immunization, BP control, oral health
- PC-oriented health care results in increased patient satisfaction

Chronic Care Model. The Chronic Care Model (Wagner) focuses on how PC practice can restructure / reorient for improved clinical care. Research on application of Chronic Care Model elements is at www.improvingchroniccare.org, and research funded by Robert Wood Johnson Foundation and performed by RAND and UC at Berkeley on three Chronic Care Model collaboratives (<http://rand.org/health>).

While findings have varied from study to study, studies have generally found that the application of elements of the Chronic Care Model improves quality and health status and reduces costs. One effort to combine information on the Chronic Care Model from 112 different studies to derive an overall estimate of a treatment’s effect (meta analysis, Tasi et al, 2005) yielded this: interventions with one or more elements of the CCM improve clinical outcomes and processes for patients with chronic illness, and multi-faceted interventions incorporating multiple elements of the Chronic Care Model have greater impact on outcomes than single or simpler interventions incorporating a more limited number of model elements.

A second study (Bodenheimer et al, 2002) focused on cost impact and found:

- CHF studies: 3 positive for reduced use/costs; 2 negative for reduced use/costs
- Asthma: 8 positive for reduced health care use/costs; 5 negative for reduced use/costs
- Diabetes studies: 7 positive for reduced health care use/costs; 2 negative for reduced use/costs
- Savings are achievable through reduced inpatient days and fewer ER visits.
- Targeting higher risk patients results in more significant cost improvements.
- Cost benefits of temporary programs may be short-lived.
- Financial savings require aligned incentives; a favorable business case means savings must accrue to the same organization paying for chronic care improvements.

Many other reports (in the appendix to this report and outside it) document the basic research underlying medical home concepts and will not be repeated here. The current challenge has been to

assemble these into testable demonstration projects that embody enough of the joint principles to amount to fair tests of the complete medical home concept. Demonstration projects included in this review are in various degrees of planning or implementation. Many have recently started and do not have clear outcomes at this point. However, some with a longer history are showing results and a few on a meaningful scale. Two examples:

Community Care of North Carolina began in 1998 and has been statewide since 2002.

- *Population:* All Medicaid beneficiaries except the elderly and disabled.
- *Health care homes must offer* patients ongoing long-term relationship with clinician, including advanced practice nurses and PAs, provide care coordination, enhanced patient/family participation in decision-making, and ensure use of health information technology.
- *Standards:* Patients must choose a doctor or medical home; physician practices have to meet criteria such as 24 hr access, ability to collaborate with other providers, and capacity to serve as a single access point for patients; all necessary medical services must be provided directly or authorized and arranged through the practice; balanced effort around quality and cost savings.
- *Practice support:* regional CCNC entity that assists in care management, identifies resources, collects performance data, and provides feedback to practice.
- *Payment model:* Regular FFS payment; PMPM fee (currently \$2.50); CNCN network clinics also receive \$3 PMPM fee for each beneficiary. For capitation of \$5.50 / mo per Medicaid pt, practices use evidence based guidelines for at least 3 conditions, track tests & referrals, measure and report on clinical & service performance.
- *Financial results:* Significant savings to Medicaid for ER and hospitalizations (Arvantes 2007). Saved \$60M in Medicaid in 2003 and \$140 M in 2006 compared to historical FFS benchmarks; Program spent \$8.1M between 7/02 and 7/03, saving more than \$60M over historic costs; in second year \$10.2M spent but \$124M saved; 2005 savings grew to \$231million.

Geisinger Health System Care Model Redesign (Paulus, Davis and Steele, 2008)

- *Population:* 2.5 million who are poorer, older, and sicker than national benchmarks.
- *Components:* Personal Health Navigator—improving care coordination and optimizing health status for each person. 24/7 PC and specialty access; nurse care coordinator in each site; predictive analysis to identify risk trends; virtual care mgmt support, personal care navigator; EHR access to pts, providers, care mgrs—lab results, self-scheduling, secure email, EHR-based “snapshot reports” on single screen; chronic disease care optimization—to embed automatic, standard care workflows and delegate tasks; acute-episode care for CABG and other.
- *Transformation support:* Highly collaborative design; specific targets for redesign; clinical business case; multiple specific improvement methodologies; monthly performance reports on quality and efficiency; trends and improvement opportunities identified
- *Payment method:* Practice-based payments. monthly paid per physician to recognize expanded scope of practice; monthly transformation stipends per thousand Medicare members to the practice to finance additional staff, extended hours, infrastructure; incentive pool based on actual/expected costs of care if quality indicators are met.
- *Early results from first-year experience at 2 pilot sites* are promising: 20% reduction in all-cause admissions; 7% total medical cost savings. Based on this early favorable experience and participants’ assessment of a strong clinical impact, program is undergoing expansion to ten additional Geisinger sites and one non-Geisinger practice to cover more than 25,000 Medicare Advantage and FFS Medicare patients.

Other diverse examples with preliminary positive outcomes are cited in the appended summary framework on national state of the art. No doubt other demonstrations are yielding results of one kind or another not cited here.

- Boeing Ambulatory Intensive Care Unit for the sickest costliest employees with chronic conditions
- Erie County NY Partial Capitation Managed Program for Medicaid / Medicare patients with chronic disabilities
- Buffalo Medical Group NY medical home for its diabetic patients
- Veterans Administration integrated information technology in primary care
- IMPACT model for stepped care of depression in primary care—now being employed in DIAMOND initiative in Minnesota
- Horizon BCBS of New Jersey / Partners in Care for state employees & dependents with diabetes.

The state of the art in health care home outcomes is linked to stage of maturity. The foundational research on primary care and the chronic care model, along with emerging results of the many demonstration projects, will have to do for now. This literature is very strong and should encourage, not discourage investment in health care home transformation.

According to the PCPCC Medical Home Purchaser's Guide (2008), the foundational research *alone* should assure employer purchasers who are cautious about investing in a new concept such as PCMH that the concept is largely already proven (significant research on core elements that demonstrate effectiveness with quality and cost) even though there is little research on effectiveness of the PCMH as defined by the Joint Principles or NCQA PC-PCMH standards. As the Purchaser's Guide says,

“The status quo is not the answer. Some adherents of Patient-Centered Medical Home are convinced that the model will deliver superior performance, but many supporting application of the concept do so realizing that there is a risk that this might not be the case. These purchasers and payers, however, find the merits sufficiently compelling to warrant investment in pilots or phased implementations subject to formal evaluation. For them, the definition of insanity is doing the same thing over and over again and expecting a different result, and they are compelled to explore new approaches that offer reasonable likelihood of success.”

In the long run, state of the art medical home outcomes will need to include those cited in Part I of this report:

- Patient experience outcomes
- Health outcomes
- System outcomes
- Financial outcomes

With the advent of so many encouraging beginnings and demonstration projects beginning or about to begin, the state of the art in actual demonstrated outcomes for health care homes can be expected to grow over time.

Part II: An inventory of work being done locally. This has two parts:

1. A meaningful but manageable sample of Minnesota work in the area of health care home
2. A narrative distillation or summary of current Minnesota state of the art from this summary—a snapshot of common themes and significant differences.

1. A meaningful but manageable sample of Minnesota work on health care home

This is a body of Minnesota work done gathered for the ICSI Medical Home Forum (July 10, 2008), with health plan and public system information updated in the fall of 2008. This body of thought and experience represents broad efforts of Minnesota groups seriously trying to design, evaluate, implement, and test health care home concepts from clinical, systems, financial, and policy perspectives “in real time” and hence can be considered demonstration projects that are among the primary or at least most articulate sources of current Minnesota “state of the art. *The demonstrations below comprise this sample and are summarized, paraphrased, or abstracted in an attachment.*

Provider groups

- Family Health Services Minnesota
- Fairview
- HealthPartners Medical Group
- Marshfield Clinic (Wisconsin)
- Mayo Clinic Primary Care Internal Medicine
- Northpoint Clinic / Health and Wellness Center
- Park Nicollet Health Services
- Dept. of Family Medicine and Community Health, U of M / UMPHysicians
- CentraCare Medical Home Team
- CentraCare Clinic

Public Sector

- MN Dept of Human Services / MN Health Dept. Provider Criteria
- Rural Health Care Delivery—A New Model. MN Dept. of Health

Health Plans

- Blue Cross Blue Shield of Minnesota
- Preferred One
- HealthPartners
- UCare Minnesota
- Medica

Other

- ICSI DIAMOND Initiative; “medical home for depression”
- West-Central Minnesota Values Health: A pilot program

2. A narrative distillation or summary of current state of the art in Minnesota that includes a snapshot of common themes and significant differences in:

- A. Goals for healthcare home
- B. Governing or operating principles invoked
- C. Components or functions
- D. Outcomes demonstrated

A. Goals for healthcare home—Minnesota state of the art

Common themes: A concordance in goals for medical home appears across Minnesota demonstrations. The following goal-related statements across the Minnesota work surveyed amounts to “the Minnesota state of the art in healthcare home when it comes to what the goals are.”

The overarching goal theme in Minnesota demonstrations is “The Triple Aim: Health, Experience, Affordability”. Underneath that is:

Health

- Patient and health outcomes (such as publicly reported measures by MN Community Measurement)

Experience

- Patient engagement and activation
- Patient access
- Patient-centered or relationship-centric practice; personalized care

Cost / affordability:

- Reduced use of resources; ER, hospital, unnecessary care

System outcomes:

- Physician and staff satisfaction
- Reliable delivery of best practices in healthcare

These Minnesota goal themes are quite consistent with the state of the art national goals and are consistent across Minnesota provider groups, public systems, and health plans. They are also consistent with desired outcomes of health care home outlined in “Outcomes” part of this report.

The Minnesota goal themes distilled here are articulated in a less specific or narrative way than the national goal themes, probably because they were taken from brief survey responses rather than from lengthy published white papers and evidence-based position papers. More specific or narrative goal statements from the Minnesota demonstrations could no doubt be written if the need arises and would probably be quite consistent with goals expressed in the first part of this report on “Outcomes”.

Differences in content or emphasis—Minnesota goals. While Minnesota health care home goals all revolve around “the triple aims of health, experience, and affordability”, there were differences in what rose to the top for a brief survey:

- *Specificity of health outcomes or measures.* Groups differed on level of specificity of desired outcomes, and most but not all cited Minnesota Community Measurement as a target measures set.
- *Workplace outcomes* such as productivity and absenteeism. These goals are likely implicit, but only one (DIAMOND Initiative) was explicit about this in this survey.
- *Panel size, growing the practice.* Two groups mentioned this as a medical home goal
- *Payer satisfaction.* One group mentioned this specifically, but it is likely implicit when it comes to multi-stakeholder planning and implementation of medical home.
- *NCQA or other medical home certification.* At this point, only one group cited this as a goal, although that does not mean others do not have some form of certification in mind, particularly in view of the MN state provider criteria published in 10/08 (after this survey data was collected).
- *A sustainable model of primary care / economically viable primary care.* A couple of groups featured this as a goal, while for others it is probably implicit in their plans
- *Eligibility / reach of public insurance programs.* One group specifically featured this as a goal.
- *Behavioral health integration when it comes to care management.* One group featured this as a goal or value, but this does not necessarily mean it is not a goal for the others.

Goal-related language in the Minnesota demonstrations. The common themes and differences distilled above can be seen from this sample of goal statements from the various demonstrations:

- . . . Improved patient outcomes as measured by MN Community Measurement. . . high patient satisfaction and scores. . . high payer satisfaction. . . (Family Health Services Minnesota)
- . . . Improved outcomes reported through MN Community Measurement. . . improved patient engagement & experience. . . eventually reduced use of resources to achieve these ends (Fairview)
- . . . Goals and measures related to the Triple Aim of experience, health, affordability. . . NCQA Medical Home recognition, with its measures. . . (HealthPartners Medical Group)
- . . . Improved access. . . increase in quality measures. . . increased physician, staff, and patient satisfaction. . . ability to increase panel size in primary care. . . reduction in cost . . . a more consistent and efficient work flow across the system. . . (Marshfield Clinic)
- . . . Performance on MN Community Measurement. . . panel size per FTE. . . PMPM costs.
- . . . All participants with a care plan. . . an annual visit (PE). . . a patient-centric and relationship-centric practice. (Northpoint Clinic and Wellness Center)
- . . . Improved clinical outcomes for adults with chronic conditions. . . improved child/youth outcomes: decrease in ER visits, hospitalizations, school absences. . . increased sense of partnership with professionals. . . improved care team satisfaction with communication and coordination of care. . . improved efficiency of care. . . improved systems outcomes: decreased duplication, decreased fragmentation. . . (Park Nicollet)
- . . . Achieving publicly reported quality targets. . . improved patient satisfaction. . . growing practice via more satisfied pts appreciating the value we offer. . . pay our way by doing better, more efficient, effective, personalized primary care. . . (Dept of Family Medicine and Community Health, U of M / UMPhysicians)
- . . . Improvement in Medical Home Family Survey (part of MN Med Home Learning Collaborative) and Medical Home Index. . . open, transparent organization that allows patients to be seen at facility of choice with preference of physician and time. . . (CentraCare Clinic / CentraCare Medical Home Team)
- . . . Improve the health of Minnesotans. . . improve patient and family experience. . . redesign care to improve value—quality / costs. . . (MN Dept of Human Services / Dept of Health)
- . . . Integration of rural clinic, hospital, long term care and other services. . . stabilize rural primary care, expand care coordination . . . address unmet needs for mental health, dental, home care and other community health services. . . (MH Dept of Health Office of Rural Health & Primary Care)
- . . . Extend the eligibility reach of the MinnesotaCare program in a 10-county area. . . services to uninsured & underinsured persons of all ages. . . preventing & managing chronic disease and persistent conditions / multiple chronic conditions. . . affordable health coverage option. . . comparable access to care for the economically vulnerable. . . integration of medical care, mental health care, public health, social services, other county resources, school and worksite services (West Central Minnesota Values Health pilot program)
- . . . Improvement in health outcomes leading to a reduction in the cost of care. . . medical home processes and structures being paid for are being used well. . . (Blue Cross Blue Shield of Minnesota)
- . . . Decreased ER and hospitalizations. . . (Preferred One)
- . . . Improved quality on MN Community Measurement or other standard sources. . . improved patient satisfaction / experience. . . reduction in avoidable and unnecessary healthcare costs. . . reliable delivery of best practices in health care. . . establishment of a sustainable model of primary care. . . (HealthPartners)
- . . . Clinical outcomes such as on MN Community Measurement. . . patient/member satisfaction. . . physician satisfaction. . . reduction in total cost of care. . . participation measures. . . process measures / outcomes such as on clinic-based care management. (Medica)
- . . . Patient activation / engagement. . . patient satisfaction. . . patient outcomes—response & remission rates. . . care manager retention and job satisfaction. . . primary care provider and psychiatrist satisfaction. . . overall health care effect. . . fewer admissions or ER visits. . . better productivity and absenteeism in the workplace. . . (ICSI DIAMOND Initiative)

B. Health care home operating principles—the Minnesota state of the art

Common themes—operating principles

While few Minnesota demonstrations explicitly cited the “Joint Principles of Patient-Centered Medical Home” (AAFP, AAP, ACP, AOA; 2007), review shows it can be regarded as the common backbone upon which Minnesota demonstrations hang their components and criteria. As such, the “joint principles” can be regarded as representing the Minnesota “state of the art”. But important locally tailored variations and additions to this set of principles also emerged that may arguably push the state of the art to a level higher:

1. *Public performance reporting.* Minnesota demonstrations give greater and more explicit emphasis on this than in the joint principles.
2. *Leadership and cultural readiness.* Minnesota demonstrations almost all strongly emphasize that health care home requires deep culture change and leadership development regarding team care, provider expectations and relationships, different clinic infrastructure / habits, and realistic timeframes for accomplishing this. Many specifics are included in their survey responses. Leadership and culture change is elevated to the list of operating principles in a way that is not done in the joint principles or as consistently in the national state of the art such as done in AAFP / TransformMED.
3. *Collaboration between stakeholders.* The Minnesota demonstrations, like many national ones, emphasize the need for multi-stakeholder, multi-payer collaboration or alliances, including cooperation between providers and health plans. While this appears only indirectly in the joint principles (care coordination across the complex care system), it is featured in the Minnesota demonstrations.
4. *Coordination of care across a larger continuum of care.* At least some Minnesota demonstrations (mostly rural in focus) featured coordination of care beyond that in the medical home itself or closely allied specialties to include hospitals, nursing homes, rehab, dental, public health or community services.

Differences in content or emphasis: Not all operating principles were the same or enhancements on the “joint principles”:

- *Medical home recognition process.* There was mostly not a clear pledge to go through medical home voluntary recognition process, as shown in the national state of the art summary, although state provider criteria were released by Dept of Human Services after this information was gathered.
- *Care process / workflow streamlining.* Some demonstrations featured the creation of standard care processes and clinic office practices to reduce waste, improve experience, and shift the right part of the work to the right provider—something required for teamwork.
- *Behavioral health integration.* A minority of demonstrations explicitly featured behavioral health integration as part of medical home. Even so, it is not clear what kind or amount of behavioral health is to be included within the health care home and what part is regarded as an outside specialty service.
- *Patient-centered and/or disease-centered orientation.* Some demonstrations are very explicit about distinguishing patient-centered approaches that involve patient story and context across all conditions. All others also aspire to patient-centered, but aren’t as explicit about the difference between this and diagnosis or condition-oriented philosophy or function.
- *Patient involvement in improvement ideas.* Patient engagement is a principle for everyone, but this appears mostly in regard to care, decision-making, patient preferences, and self-management. At least one demonstration also features patient involvement in practice improvement ideas—design and inspiration for redesign.
- *Enrollment in public programs.* All demonstrations feature access, but one explicitly features greater enrollment in public programs for those who qualify as a way of giving economically disadvantaged populations comparable access to other populations.

Principle-related language in the Minnesota demonstrations.

- . . . Patient-centered. . . patient choice of provider, time, and place. . . continuity of care. . . group access to records. . . transparency and value of patient care and outcomes (Family Health Services Minnesota)
- . . . Transparency of outcomes & high expectations. . . quality committee to set and lead initiatives. . . upper executive leadership putting emphasis on quality as "Job 1." (Fairview)
- . . . Standardized, reliable work flows and the right person doing the right job as foundation of medical home. . . team care with cultural readiness for providers and RN's to delegate on the care team. . . provider cultural norms necessary for transformation. . . (HealthPartners Medical Group)
- . . . Standardized care processes. . . team care. . . shifting unnecessary or clerical work from provider such as inventorying meds, allergies, past medical, family and social history. . . (Marshfield Clinic)
- . . . A population focus. . . team based care. . . stratification of care based on patient need. . . care and appointments that match services with actual needs. . . (Mayo Clinic Primary Care IM)
- . . . Patient-centric & relationship-based. . . holistic--not siloed into disease and condition-specific models. . . medical home based on primary care team, not specialized team care. . . see patients in context of their world to optimize their health, by getting to know pt's stories and who they are. . . (Northpoint Clinic)
- . . . Collaboration & communication. . . using expertise of entire team. . . enhanced access such as open scheduling, expanded hours, new options for patient / clinician / staff communication. . . service coordination. . . team approach for chronic conditions. . . includes planned, proactive visits. . . (Park Nicollet)
- . . . Work collaboratively to improve. . . change is our friend. . . teams solve problems better than individuals. . . restore a sense of "fun" to our work. (Dept of Family Medicine, U of M / UMPhysicians)
- . . . Partner with families—source of improvement ideas and dimension we could not create on our own. . . ongoing QI . . . teamwork among stakeholders. . . positive reinforcement. . . (Centracare Clinic)
- . . . "Start with the end in mind"—what we want to accomplish, what success looks like. . . all Minnesotans benefit from reforms, market-wide implementation—not just government programs. . . seek & expect unprecedented collaboration among public & private partners—patients, families, national and local HCH models, physicians, other professionals, health plans, hospitals, advocates. . . (MN DHS / MDH)
- . . . Joint principles of patient-centered medical home. . . patient-centered connections / integration across rural continuum of care—personal behavior, ER, PC, specialty, hospital, rehab, long-term, palliative, nursing, home care, dental, mental health, pharmacy, public health, transportation, schools, community education, churches, business. . . rural hospitals often in a coordinating role. . . (MDH Rural Health Model)
- . . . Patient centered (not physician centered and just *called* "patient centered"). . . patient self-empowered. . . team based. . . working at the top of one's license. . . primary care based. . . care coordination. . . beyond 1:1 face-to-face encounters. . . (Blue Cross Blue Shield of Minnesota)
- . . . Accessible, comprehensive primary care, health, and medical services chosen by the patient, delivered by multidisciplinary teams, coordinated with other providers and health plans. . . systems based. . . using data. . . patient communication tools. . . care coordination. . . evidence-based. . . individualized. . . accountability for outcomes. . . collaboration between medical home and health plans. . . (HealthPartners)
- . . . Realistic estimation of effort and resources required to function as a certified medical home. (UCare)
- . . . Comprehensive chronic care. . . at point of service to reduce fragmentation and cost. . . member-centric / patient-centered. . . new reimbursement model for chronic disease. . . culture change to team care. . . organization leadership. . . improved provider reporting. . . public reporting. . . P4P. . . (Medica)
- . . . Collaborative care with team approach—a culture shift. . . a systems approach. . . communication links set and working. . . clear job roles and responsibilities. . . piece of the job you are most qualified to do. . . trust that others on the team and systems are doing what they are supposed to do. . . (ICSI DIAMOND Initiative)
- . . . Financing based on quality, experience, outcomes and role in helping maintain them in cost-effective manner. . . healthcare homes, chronic care mgmt, care coordination, EBM, wellness. . . info for wise care and purchasing decisions. . . HIT. . . enroll more eligible for public programs. . . adaptability to urban & rural settings. . . employment to reduce dependence on public programs. . . (West-Cent MN Values Health)

C. Minnesota Health care home components and performance criteria

Common themes in the state of the art medical home components and criteria. As would be expected, the Minnesota operating principles described earlier overlap considerably with, or are embodied by, the components and criteria. The common core of components is quite similar across Minnesota demonstrations:

1. Care management / care managers / proactive system for following rosters of patients
2. Team care structure and leadership broadly defined
3. EMR
4. Registry / preventive and chronic care reports
5. Evidence based guidelines embedded /
6. Systems for patient self-management, decision making, patient activation, or involvement in practice
7. Pre-visit, between visit care / planned exams / standardized workflows / QI as a normal part of clinic life
8. Systems for performance measurement, tracking, feedback, and reporting

Differences in content or emphasis regarding components: There are few if any major differences not already discussed in earlier sections on goals and operating principles, although again, each Minnesota demonstration features or emphasizes slightly different things and uses slightly different language.

About medical home qualifying criteria. The Minnesota demonstrations clearly aspire to seeing competent health care homes develop in Minnesota and are not naïve about what that will take. But unlike the national papers and demonstrations, most Minnesota demonstrations did not in this survey specify or aspire to particular medical home qualifying tools or criteria such as the NCQA PC-PCMH (although there was no specific question on this in the survey).

Presumably all serious demonstrations will at some point want to evaluate themselves in some way on medical home criteria and use one or more of the standard tools such as described in the national state of the art section of this report.

In addition, Minnesota projects have the additional opportunity and incentive to evaluate themselves against the *Provider Criteria of the Minnesota Dept of Human Services and Dept. of Health*. This is the result of considerable deliberation within Minnesota and can be considered part of the Minnesota state of the art when it comes to qualifying criteria.

These *Provider Criteria* appear in the Minnesota state of the art summary attachment and are compacted into a 1-page summary on the next page.

Provider Criteria; summarized for this report from Primary Care Coordination MN Dept of Human Services, 10/31/08

1. Patient-Centered Care Coordination

A. The clinic must provide care coordination using staff that:

- Work in the PCC clinic. . . protected time and space to coordinate care. . . authority to delegate
- Broad skill set. . . medical terminology. . . cultural competency. . . patient & family centered care. . . prioritize clinical needs. . . access medical and social service resources. . . communicate complex info to patients, families, providers. . . basic computer skills

B. The clinic must engage patients and/or families in medical care by:

- Using a care coordination team consisting of the provider. . . care coordination staff. . . other clinical staff
- Meeting as a team with the patient and/or family to assess, plan, manage care. . .
- Using the patient / family preferred mode of communication. . .
- Including the patient and/or family in shared decision-making
- Providing on-call, 24/7 access directly or via a phone triage to a provider with access to registry data
- Providing access to appointments within one day for acute care; timely transition after discharge. . .
- Providing an updated version of the Care Plan to the patient and/or family
- Communicating with local social service and community providers to ensure optimal health and care. . .
- Managing and supporting care needs at appropriate intervals of the patient's care plan and acute needs. . .

2. Care Plan: The clinic must create and maintain a comprehensive Care Plan for each patient:

- Developed with direct participation of the patient and/or family. . .
- Provided to the patient and/or family after significant updates
- Updated by the care coordination team per protocol to ensure continuous relevance. . .
- Updated with the patient and/or family at least once every year
- Contains, at a minimum:
 - 1) Chronic diagnoses, allergies, physical & mobility status, level of independence, ADLs, IADLs, relevant physical findings & labs, ongoing medications, major procedures, durable medical equipment, community & education providers, specialist partners, family caregivers, patient and family unique communication needs & preferences, specific cultural & language requirements
 - 2) Unique goals and plans of care for: preventive care, chronic care, acute exacerbations of known chronic diseases, plans for care and early contact with the care coordination team during acute episodes, transitions for discharge from hospitalization, end-of-life care and/or advance directives, when appropriate, patient and family unique care needs and preferences

3. Registry:

A. The clinic must create and maintain a patient Registry database which:

- Is electronic, searchable, and available within the clinic site
- Is used to manage preventive care and chronic disease care for the PCC patient panel
- Is available to on-call provider peers and for phone triage systems
- Contains, at a minimum:

Name, age, gender, racial/ethnic background, primary language, contact info, family/guardian contact info if applicable, privacy or confidentiality concerns, diagnoses, allergies, chronic medications, last date of registry update

B. The Registry may be a subset of the Care Plan as long as the criteria listed in 3a above are met.

4. Quality Improvement:

A. The clinic must create an internal Quality Improvement Team

- Consists of participating provider, care coordination staff, at least 2 patient and/or family representatives (if applying as a clinic site, patient and family representation should roughly be in this proportion to the number of participating providers), the clinic administrator, other clinic staff as needed.
- Meets at least monthly; creates goals for practice and care delivery improvement. . .
- Plans, implements, and records results of quality improvement cycles; reviews and measures progress towards goals
- Incorporates social service, education, mental health, other community providers when appropriate to meet goals. . .

B. Representative members of the clinic quality improvement team (providers, care coordinators, patient / family representatives) participate in ongoing QI training. . . methodology. . . share information & learning between clinics through multiple QI cycles; foster intra-clinic and intra-system improvement processes.

C. Measurement of results: The clinic must survey patients and/or families to measure: 1) satisfaction with care delivery, 2) level of engagement in patient care; provide reports (via existing quality reporting systems or directly to DHS) as determined by State to assess patient health outcomes and quality of care delivery.

Component-related language in Minnesota demonstrations. The list of excerpts below helps reveal the common themes and differences in Minnesota project language for health care home components and criteria—and naturally overlaps considerably with the language for operating principles.

- . . . Care management. . . EMR to visualize, track and review data. . . (Family Health Services MN)
- . . . Care managers working with rosters of patients. . . team care. . . MTM, CDE's, nutrition counseling, preventative care reports (CA screening, immunizations) upstream from when patients need more expensive care. . . ICSI guidelines if available. . . (Fairview)
- . . . Care managers working with rosters of patients to make sure people are getting the f/u they need
- . . . Standardized workflows apply to all patients, not just chronic care. . . different roles doing different parts of the work. . . care coordination / care management. . . patient self management connections to community. . . EMR. . . between-visit care. . . (HealthPartners Medical Group)
- . . . Care teams. . . adult planned visit / previsit for prevention / chronic disease. . . secure messaging and e-visits. . . less on face-to-face visits in the future (Marshfield Clinic)
- . . . Multidisciplinary care teams. . . advanced triage at team level (not centralized) . . . planned care. . . stratified chronic disease mgmt. . . shared patient decision-making. . . virtual consultation (Mayo Clinic PC IM)
- . . . Care coordinator. . . registry. . . language-specific data base (paper) for mgmt. . . care plans (Northpoint)
- . . . Personal physician leads care team. . . care coordination across all elements of health care system. . . registries. . . routine use of HIT. . . evidence -based medicine and decision-support tools. . . care plans for complex or chronic conditions. . . QI and performance measurement systems. . . (Park Nicollet)
- . . . Systems for continuity of care. . . chronic care systems. . . preventive care systems. . . smoking cessation. . . pharmacy med coordination. . . mental health integration. . . (Family Medicine U of M / UMPHysicians)
- . . . EMR. . . registry. . . care management. . . open access. . . after hours care. . . weekly team meetings. . . parent networking group. . . networking with community providers. . . QI infrastructure in clinic. . . (CentraCare)
- . . . Primary care team. . . non-face-to-face and group visits. . . care coordination within the home and with community (specialists, hospitals, home health agents, public/parish nurses, etc.). . . registry. . . care plan owned and developed with the patient, family, and all who provide care and support. . . (BCBS MN)
- . . . Team care. . . care coordinator. . . chronic care model integration. . . pre-visit, post-visit & between visit planning. . . registry. . . patient education, empowerment, activation. . . EBM guidelines. . . measurement, tracking, reporting system. . . data exchanges between clinic & claims data. . . health risk assessment linkage. . . risk stratification / predictive modeling. . . (Medica)
- . . . Registry. . . guidelines. . . standardized assessment tool. . . specific approach to relapse prevention for pts in depression remission. . . clinic-based care manager. . . consulting psychiatrist. . . (ICSI DIAMOND)
- . . . Eligibility & enrollment. . . health assessment & screening. . . care coordination & delivery. . . payment & financing. . . (West Central MN Values Health pilot)

D. Minnesota health care home outcomes demonstrated.

As said at the outset, “Health Care Home” is not a mature product or enterprise nationally or in Minnesota. Pilot or demonstration projects in Minnesota are clearly consistent with or based on national foundational research or demonstrations outlined earlier.

Minnesota projects of this review are in various degrees of planning or implementation. Many have recently started and do not have clear or widely shared outcomes at this point. However, as the healthcare home concept and implementation grows and the demonstrations mature, “hard” outcomes will emerge.

One example of this is recently announced preliminary and limited outcomes from the ICSI DIAMOND Initiative (“a medical home for depression in primary care”). This early 6-month data from many participating primary care practices shows a 50% response rate to the program and a 35.5% remission rate, which is considered quite promising.

This DIAMOND stepped care method involves many principles or components of health care home (as applied to depression), such as primary care providers working with care managers; care managers supervised by a consulting psychiatrist using a registry; evidence-based care protocols based on the previously reported IMPACT study, performance reporting, a modified care management fee payment system on top of FFS, and a broad coalition of provider groups, health plans, and quality organizations behind the effort and coaching the practices.

There may well be other preliminary, recently announced, or privately held outcomes for Minnesota demonstrations that were not reported for this survey. With the kinds of solid beginnings and momentum evident in Minnesota and the nation, the table appears set for seeing more and deeper “hard outcomes” for medical home.

Some words of wisdom on “beginnings” for the journey:

- “Beginnings are always messy” (John Galsworthy, Nobel Prize for literature, 1932)
- “Mighty things from small beginnings grow.” (John Dryden; British poet, dramatist and critic)
- “To have begun is to have done half the task” (Horace)
- “All this will not be finished in the first 100 days. Nor will it be finished in the first 1,000 days, not in the life of this Administration, nor even perhaps in our lifetime on this planet. But let us begin”. (John F. Kennedy in his inaugural address)
- “Change starts when someone sees the next step.” (William Drayton; American judge)
- “When the music changes, so does the dance” (African proverb)

Part III. Promising models for setting realistic expectations for developing health care homes that can actually achieve desired outcomes

The health care home concept and vision (when implemented) is a significant departure from the status quo, and the Minnesota demonstrations in particular emphasize the many shifts required. For example, Minnesota demonstrations all included information on the leadership and change management approaches they are employing. Here is a sample.

- . . . Our entire leadership team attended and endorsed culture change to lead a culture of quality. . . (Family Health Services Minnesota)
- . . . Cultural adaptive work offered through a year-long course > 60 hours for medical leadership. . . representative quality committee leading system decisions at a local level. . . (Fairview)
- . . . Established approaches to implementation and spread. . . extensive work to clarify our Provider Compact setting cultural norms necessary for this transformation. . . cultural ability for those in professional roles (providers, RN's) to delegate to others on the care team. . . (HealthPartners Medical Group)
- . . . Moving from pilot to full implementation, leaders will need to be clear that this is not a passing fad but is the way we deliver healthcare. . . a dynamic process with continuing changes and improvements. . . culture has not demanded adherence to centralized processes. . . face to face visits with the physician doing much of the care has been the norm. . . transitioning to a team process will challenge some. (Marshfield Clinic)
- . . . Leadership is essential to success of medical home. . . understands medical home principles. . . enforces the need for this as a priority for the organization. . . must find resources. . . job descriptions, workflows, standard work, educational processes related to medical home. . . (Park Nicollet)
- . . . Joining the ICSI Creating a Quality Culture. . . improved "meeting hygiene" and meeting management has increased our productivity. . . building quality and team-building methods into almost all group activity. . . (Dept of Family Medicine and Community Health; U of M / UMPPhysicians)
- . . . People in leadership understand the project. . . in full support or cannot move beyond minor improvements. . . essential to align all the different areas that must work together e.g. lab, x-ray, front desk, HR, media. . . an involved physician champion essential . . . improvements built into daily working of the clinic. . . not rely on the efforts of one or a few people. . . (CentraCare)
- . . . Clinics will have to want to become a medical home. . . have a champion to lead effort. . . work hard to make the necessary cultural changes such as team care, work flow for other forms of access, coordination of care outside the medical home and with community, discipline of identifying gaps in care. . . reaching out to patients outside office encounter. . . skills to help patients manage their conditions. . . (BCBS of Minnesota)
- . . . Senior group and plan leadership fully engaged. . . incorporating into strategic planning. . . sponsoring work to move into operational detail. . . considering payment reform options. . . measurement and accountability. . . coordination between health plan and delivery system. . . LEAN change management. . . (HealthPartners)
- . . . Led by two Senior VP's. . . an internal Medical Home Steering Committee. . . leadership team participating in a Patient Centered Medical Home Collaborative sponsored by Alliance of Community Health Plans. . . (UCare Minnesota)
- . . . Steering Committee to get program running and high-level support. . . administrative leadership for building, purchasing, infrastructure such as a registry. . . leadership champion within collaborative team for ongoing buy-in with all participants. . . identify the right people and skills for the right roles. . . local team leadership to provide frequent feedback, ongoing support, help overcome challenges. (ICSI DIAMOND Initiative)

The changes required to shift to medical home are taking place in developmental steps over time, with significant attention to leadership and culture change such as described above. As particular health care home implementations mature, they become more capable of achieving not only their own goals, but achieving the desired hard outcomes such as improved population health, patient experience, and financial value. Realistic expectations for these hard outcomes therefore need to be scaled to the level

of development or maturity of particular medical home implementations, along with some ways of thinking about setting appropriate timeframes for different levels of outcomes. This report does not claim to have an answer, but does point to several promising models or ways of thinking about these topics that are relevant when describing and advancing the state of the art:

- A developmental sequence from “pilot to project to mainstream”
- Combining a critical mass of “component technologies—from idea to invention to innovation”
- Diffusion of innovation, spread, or propagation —from one organization to another

A developmental sequence from “pilot to project to mainstream”. Davis (2001) described a developmental sequence by which behavioral health providers were integrated into primary care clinics over a period of time in a large care system, something that required significant cultural shifts. He described this as moving from “pilot to project to mainstream” and characterized it this way:

| | “Pilot” | “Project” | “Mainstream” |
|--------------------------------|--|---|--|
| | A protected demonstration of feasibility & value | Demonstrations led together as a visible, sponsored effort to create wider change | A full scale shift to a new “way of life” in the practice or community |
| The “end in mind | Demonstration of improved care for a particular group of patients served by a limited scale collaborative team | Better care and service within the larger clinic or community; a better match between design of clinic services and patient needs | A care system that routinely delivers the right care at the right time in the right places by the right clinicians and teams |
| Core group to engage | A few motivated clinicians and staff who want to do things differently and learn from the results | Interested clinic/community leaders including clinicians, managers, operations/financial staff | Care system / community leadership across levels and areas |
| Common interests to build on | Clinician desire to better serve their own patients and to improve their own working relationships | Clinic / community leader desire to better serve more of its population of patients, learning from the pilot | Leadership desire to improve health, healthcare, service, and resource stewardship for an entire population of patients |
| First steps | Finding each other and working out a good-enough startup plan | Establishing clinic / community ownership and a viable clinic integration/implementation team | Establishing care system ownership, executive vision and direction at the highest level |
| Operational or financial tasks | Local and pragmatic solutions, often non-standard or outside the usual system; maybe seed money or time | Pragmatic solutions workable within the larger clinic system with expectations of financial and time workability | Carefully crafted system-wide clinical, operational and financial designs and habits to support a new way of life throughout the care system / community |

In this model, different stages carry different expectations, and it is important to align the expectations for results with the stage your work is at. For example, a small-scale *pilot* or demonstration of feasibility with a limited population or provider segment can’t be expected to achieve population health outcomes on a meaningful scale—even if successful within its limited scope. But the bar on expected outcomes can be raised for a more comprehensive and well-developed *project* healthcare home implementation. And a fully mature, well-developed, *mainstream* healthcare home (with proper connections to everything around it) can be expected to do even better.

Since this developmental sequence takes place over time, appropriate expectations for clinical, operational, and financial goals should be established at each stage to avoid either premature disappointment with results or leaving the bar too low. For example:

- In a pilot, things start small. If a pilot is successful or popular, people may want to start applying heavier service demands on it—“see my patients too”—in a way that is out of scale with pilot capabilities. In this event, even a successful pilot can acquire a bad reputation for access or other reasons. The lesson is: don’t apply mainstream demand to a pilot project. When pilot success and demand escalates, consider shifting to a “project” stage that rolls more effort, sponsorship, visibility and capabilities into the best ideas learned from the pilot.
- Ultimately, clinical, patient experience, and financial outcomes need to be achieved on a meaningful scale. This means knowing when to move the most successful “projects” that may have acquired multiple sponsors, clinics, subprojects, and resources into the mainstream, where they become “just the way we do things” or a “new way of life” rather than a promising appendage to a core system that hasn’t changed. This is the cultural shift that so many health care home demonstrations are anticipating.
- Note that at each stage the expectations and measures—what counts as success—are likely to be different, and are promoted to the next level as things move from pilots to the mainstream. The lesson from this work is to know which developmental stage your work is at and then use matching clinical, operational, service, and financial expectations and measures—raising the bar for them all as a package when shifting gears to the next level.

Combining a critical mass of “component technologies” / “from invention to innovation”. Senge (1990) points out a similar developmental sequence—“from invention to innovation” which also contains important lessons for healthcare home development. He observes that people are often frustrated that otherwise successful working inventions and projects often fail to make a difference in the mainstream way of life in the industry they are part of. Senge tells the story of the development of *air travel as a way of life*. With his help, let's contrast *idea*, *invention* and *innovation*.

From *Idea* to *Invention* to *Innovation*

| Developmental stage | In aircraft | In healthcare |
|---|--------------------------------------|--|
| Idea: This <i>would</i> be valuable and <i>should</i> work | daVinci’s “helicopter” | Integrated visions of ambulatory care or health care home |
| Invention: I’ve got <i>one</i> that works | Wright Bros’ 1903 Kitty-Hawk biplane | Limited prototype demonstrations of feasibility |
| Innovation: This works <i>over and over</i> , on a <i>meaningful scale</i> , and is <i>financially practical</i> for the purpose intended | 1935 McDonnell-Douglas DC-3 | A widely repeated, locally tailored, clinically excellent, operationally facile, and financially practical healthcare system |

(Senge contrasted “invention” and “innovation”. This was extended to healthcare by Peek & Heinrich (1995); Peek (2008)

In aircraft development, the *ideas* were around for a long time, for example famously in DaVinci’s drawings of what looks faintly like a helicopter. Then the Wright Brothers came along with their 1903 biplane that showed flight could be accomplished—at least once. Then for many years many different aircraft were produced and flew, but none of them were particularly commercially successful or moved us into the era of air travel—until the 1935 McDonnell-Douglas DC-3.

Why did previous aircraft fail commercially, remaining mere *inventions*, while the McDonnell Douglas DC-3 *innovation* ushered in the era of commercial air travel? Senge explains that five "component technologies" worked *together* as an "ensemble" in one plane. These were:

1. Radial air-cooled engines
2. Variable-pitch propellers
3. Lightweight molded "monocoque" body
4. Retractable landing gear
5. Wing flaps

All five were needed—*working together—at the same time*. A Boeing plane with only *four* of these component technologies flew, but failed to make a real difference in air travel the previous year.

McDonnell Douglas took an *integrative approach to the disparate component technologies* of the DC-3, rather than just improving components as if independent of each other. The company set itself the task of building a *complete airplane*—and saw itself as an *aircraft company* not just an engine company, airframe company or propeller company.

This *aircraft company* brought more to the table than expertise in separate components. It brought expertise at integrating disparate technologies (and the people who understand them) in service of an airplane that was far more than the sum of its parts. This meant letting these component technologies *affect each other* in service of the overall airplane—not letting them compete with each other for dominance, engineering elegance, or the private satisfaction of experts in each component.

The ability to pull disparate technologies and people together in service of the complete airplane may have been McDonnell Douglas' most important competency and why their plane swept away the competition in 1935 to usher in the era of commercial air travel.

The lesson for health care home from this work is twofold:

1. Mainstream success with health care home on a meaningful scale (the "innovation") is likely to require some minimum set of components, all harmonized to work together at the same time. Which ones are critical to usher in *innovation* is yet to be discovered, although the state of the art is narrowing down to some fairly standard components. There exists considerable work on this already, e.g. Solberg et al (2008), Margolis et al (2007) and Fraser (2006)
2. The integrative competency to harmonize those components (and experts) to work simultaneously as an ensemble for the benefit of the "complete health care home" may be a competency in its own right for aspiring organizations to be conscious of and strive for.

Diffusion of innovation, spread, or propagation—from one organization to another. Health care home pilots will presumably become larger projects and finally mainstream implementations or "innovations" that promise to usher in a new era in healthcare in a particular organization, community or region. The question becomes how to spread or propagate or diffuse that innovation to other systems, rather than remaining "islands of improvement" (Plsek, 2005) A rich body of literature can be drawn on here.

Diffusion of innovation. Rogers (1983) says that adoption of an innovation in any given population follows a pattern. It starts with an innovator, often one person with a new idea. The innovation spreads slowly at first, usually through the work of pioneers or change agents who actively promote it – then picks up steam as more and more people adopt it. Somewhere along the line it reaches a take-off point when the number of early adopters reaches a critical mass. At that point the innovation gets a life of its own, as more and more people talk about or demonstrate the innovation with each other. The task is to

get things up to the take-off point. Rogers (1983) identifies five characteristics that go with successfully spread innovations:

1. Relative advantage. Is the innovation distinctly better than usual practice? Will people perceive it as better? If not, the innovation will not spread quickly, if at all.
2. Compatibility. How does the innovation fit with past experiences, present needs, and existing values? If it doesn't, it won't spread well. If people feel like they have to become very different people to adopt the innovation, they will resist it. "I can't play this new game and still be me!"
3. Complexity. How difficult is the innovation to understand and operationalize? The more difficult, the slower the adoption process. "This is just a way to make life harder."
4. Trialability. Can people "try out" the innovation first? Or must they commit to it all at once? If the latter, people will be quite cautious about adopting it. "Can't I return this if I don't like it?"
5. Observability. How visible are the results? Is there a score? Can the scores be observed and understood by others? If not, the innovation will spread more slowly.

In addition, a communication channel must be able to reach potential adopters, time is required for spread, and the structure of the surrounding social system can facilitate or impede spread.

In *The Science of Spread: How Innovations in Care Become the Norm*, Bodenheimer (2007) briefly summarizes the "spread" literature starting with Rogers and goes on to describe how the Institute for Healthcare Improvement (IHI) bases its "spread" work on Rogers work, then to other authors on this subject. Several lessons from this paper are:

- Learning collaboratives are regarded by IHI and others as an important way to bring people together from different organizations to work on particular topics on a pilot scale. But having these teams spread their work across back home across their entire organizations has proved difficult because people are busy and may not package their messages for the majority who are not already early adopters.
- Spread of this kind is primarily a leadership responsibility that builds on those successful tests and pilots that demonstrate clear improvement over the status quo. Clear communication strategies communicate that changes of this kind are going to take place and why.
- Much of the Rogers work was done with relatively simple innovations, but spread in healthcare often involves very complex behaviors or changes—not so much "do it or not", but many small continuous interrelated changes. Innovators are not necessarily normal people in that they love changing things whereas most people are wary of change. Early adopters may be impatient with that and are often not the best messengers. Spreading innovation must reduce cost to the organization adopting the innovation (not just to someone else who benefits) or it may not become permanent (Bodenheimer summarizing Fraser, 2007).
- Patterns to watch out for (Bodenheimer summarizing Fraser, 2007):
 - Creating a pilot that can succeed, but under such non-real world conditions that it cannot possibly propagate.
 - Initially picking a population whose care can easily be improved, but the changes don't apply to most of the population. Try on populations with greatest impact, rather than those easiest.
 - A "tipping point" of 20-25% of people may not be realistic. Improvement is more of a continuous process.
 - Using Rogers categories for people (early adopter, majority, laggard) may not be wise because "laggards" may be the pragmatists who keep organizations going and validate the changes.

--Spreading improvement requires continuous measurement.

--Without courageous, curious, passionate leaders, spread programs founder. Say “implement better ideas” rather than “spread good practice” so that everyone is viewed as an implementer.

- Spread does take place. Bodenheimer describes several successful instances, including the Veterans Health Administration, Humboldt-Del Norte Independent Practice Association (small primary care practices), Cincinnati Children’s Hospital Medical Center (a pediatric academic medical center), Institute for Clinical Systems Improvement (ICSI—a quality improvement organization), and IHI’s 100,000 Lives Campaign to reduce preventable deaths in hospital.

There is far more than could be said about moving from pilots to mainstream implementations and about spreading those from one organization or region to another. What is important for this report is for readers to quickly see that:

- Work and literature does exist that organizations or demonstrations can use to move methodically from pilot to project to mainstream and ultimately spread.
- Leadership, change management, developmental sequences or spread can become a conscious part of the health care home effort, is part of what creates success, and is a topic in its own right.
- Realistic expectations and timeframes for outcomes of various kinds at various levels of maturity or program development can be put in reasonable ranges using some of these models in the literature. (Although this review did not find any such timeframes and expectations quoted!)
- There are likely ways to accelerate the developmental sequence of medical home piloting and innovation to reach those desired outcomes as soon as is realistically possible.

Part IV.

Outstanding issues to grapple with to take Health Care Home state of the art to the next level.

The following list is of questions and unexplored or “messy” areas that arise repeatedly in conversations and writings regarding health care home—and may well comprise a list of issues to grapple with to move the state of the art to the next level.

- 1. Medical home as a philosophy vs. a location-based or provider-based concept.** Medical home is a philosophy or function yes, but in the end it must also become an *embodied* philosophy—and there may be a range of legitimate embodiments for that philosophy and function. (Embodiment means some concrete form in which the philosophy is lived out like a clinic, virtual team, or whatever). Can we give examples of this embodied philosophy without suggesting that the *particular* example, or only *certain* embodiments, are eligible to be medical homes?
- 2. Medical home “anatomy” but with “physiology”—core competencies or core practices.** Much talk about medical homes concerns *components* that lead to measured outcomes—which is important. But there is a need to balance this “anatomical” view with a “physiological view” of how the components and people in them all work together functionally. One way of doing this is to accompany “component” lists with “core competency” lists so that it becomes clearer what exactly the medical home or component has to be able to do.

Even better might be a list of “core practices”—the short list of specific practice routines that every medical home has to routinely engage in—without reservation. One example of a core practice is “care management”. The concept of “core practice” means “what is recommended is actually routinely done in practice”—which is a harder edged concept than “core competency” which only means you know how—not that you routinely do.

3. Specific connections of “health care home” to everything around it. Presumably “medical home” is not the entire universe of care and relationships, yet medical home discussions often neglect to talk much about what is external to medical home but needs to be closely connected or “wired up” to it. What is the relation or connection-set of health care home with everything else around it, e.g. acute and subacute / rehab facilities and functions, long term care nursing facilities and functions, medical and mental health specialties, and public health or community services and supports. The 2008 MDH “rural health delivery model workgroup” (summarized in Minnesota state of the art) spent half of its time on “rural health care home” and the other half on “connections between rural health care home and everything else in the continuum of care”.

4. Behavioral health—what kind of “mental health” is to be a normal part of medical home and what parts are linked, but “outside” as a specialty service or other resources connected to (but not internal to) medical home? For example, many primary care systems are building internal “primary care behavioral health” capacity into their clinics—onsite—as a normal part of helping primary care providers do the behavioral health portion of the primary care mission. At the same time, mental health specialists or intensive treatment or long-term mental health care is needed outside the primary care clinic, and sometimes primary care is needed *inside* long-term MH clinics.

Another example: Some think of DIAMOND Initiative as a “medical home for depression” because of its systemic approaches, and this has added impetus to the more generic idea of better integrating behavioral health expertise into medical teams. But if “medical home” goes beyond depression or any particular disease or population (including the behavioral aspects of chronic illnesses such as diabetes, asthma, or CHF), what is the generic behavioral health function that is a core competency of medical home?

5. Medical home as anchored in diseases or populations vs. a generic system characteristic. Medical home concepts got their start in pediatric populations—more specifically children with special needs. DIAMOND has been compared to “medical home for depression”, and many systems strive for medical home-type function for chronic illnesses such as diabetes. But in the end, is the medical home concept and criteria to emphasize generic system characteristics and capabilities across all conditions and populations, or is to be focused on a subset of these? And if focused on a subset, is this only as an early developmental step toward a fully generic function or is a disease-or population-specific design the goal of “medical home” in Minnesota?

This distinction is important because it sets the stage for how to think about specific diseases or populations in medical home discussions—and what the eventual “prize” is. For example, if the medical home concept is supposed to be generic across diseases, then “redesign” isn’t just for one or two diseases, but for the whole identity and care processes. In addition, concepts like “assessing patient complexity across conditions” (such as mentioned in a number of projects) have greater meaning if “medical home” is eventually to apply across diseases and populations.

6. Appropriate expectations for medical home projects at any given time. When conversations get to setting realistic timeframes and levels of performance, it becomes challenging because there is no fully functional, established and repeatable pattern to draw from. A way of setting realistic expectations for particular “health care home” implementations is needed that takes into account how mature the project is. Quoted from an earlier section of this report:

“The health care home concept and vision is a significant departure from the status quo. As particular health care home implementations mature, they become more capable of achieving . . . outcomes desired.

Realistic expectations for . . . outcomes need to be scaled to the *level of development* or *maturity* of particular health care home implementations.

For example, a small-scale pilot . . . with a limited population or provider segment can't be expected to achieve population health outcomes on a meaningful scale—even if successful within its limited scope. But the bar on expected outcomes can be raised for a more comprehensive and well-developed health care home implementation. A mature, mainstream, connected health care home can be expected to do even better. Since this developmental sequence takes place over time, appropriate expectations for hard outcomes should be set at each stage to avoid either premature disappointment with results or leaving the bar too low. . . .”

7. A way out of a familiar provider-payer stalemate: “*Change and perform and then we’ll pay differently*” and “*pay differently and that will drive our change*”. This dilemma (and the important insights on both sides) is often heard, but usually framed as an “either-or” which is unlikely to be settled that way. On the other hand, the DIAMOND Initiative in Minnesota is a nice balance in action of these two valuable perspectives. The question is what can we learn about how to soften, balance, or harmonize these two perspectives with broader medical home topics. This may be a combination of what was learned from DIAMOND in this regard, getting stakeholders more acquainted and trusting of each other, and explicitly identifying this potential “us them” as something that will require a balanced and perhaps staged approach or general formulation of “how we get past this from here”.

8. The patient role in getting the best from “health care home”.

A. *Consumer of services / producer of health.* Conversations often talk about medical home as something “delivered” to patients as a “service” or “product” that has to “meet patient-centered expectations”. This talk often takes place implicitly in a “consumer” model in which the person buys something, has it delivered, and is satisfied or not. But getting the best from “health care home” (let alone health) requires people and communities to *play ball* with it in some way—to “produce health”, not just “consume healthcare services” (Doherty, 2006). Less clear in most medical home conversations is what role, responsibility, obligation—or even merely opportunities—the patient and family can (or even should) take to get the best for themselves out of the system. Is it important to raise the question of what if any responsibilities (or even obligations) patients and families (and even communities) will need to take on in order to have “health care home” achieve any of its ultimate outcomes like population health? What if any “mutuality of expectations” might apply, given that of course anyone can “opt out” of anything in the healthcare home. Should this issue be raised—and if so, how, when and with whom?

B. *Co-creation of clinic / process design.* Conversations also take place about patient engagement in the acceptable and patient-friendly design of the care process or design of the health care home itself, not just engagement in their own care after the health care home is all set up. What is the model for professionals and citizens or patients co-creating their clinic in a way that works for all and does not suffer from the limited perspective or accidental nearsightedness of either?

9. Health care home as seen through patient / citizen eyes. Patient engagement is featured in all papers and demonstrations, but how much do we know about what the state of the art in health care home looks like through the patient’s eyes? Or through the eyes of a responsible citizen who is not being a patient at that particular moment? Health care home designs are primarily written from what might be called an “industry” perspective and being offered to patients as a superior product with the hope that patients and populations will just plug into it. What is the case to be made to patients patient groups who haven’t yet written their own “white paper”? How can we connect the “patient

experience” outcome to the well-recognized problems as seen by the patients themselves, e.g. fragmentation and discontinuity. How do we get clearer on how the professional view of health care home *also* appeals to what already matters to patients, families, and citizens—or what we have missed about what matters to them?

- 10. What health care home is *not*, e.g., a gatekeeper model in disguise.** If primary care providers are seen again merely as gatekeepers, they will not be seen as (or feel like) advocates and helpers. Healthcare home aims to put patient health and experience first, but at same time asks providers to be stewards of resources on behalf of all of us. We can indeed improve patient experience and health outcomes while improving resource stewardship. But how do we talk about this with patients and providers in a way that doesn't sound like “dual agency”? Further develop lines of thought about decision-making, regarding both doing something and *not* doing something, as value and health driven. Distinguish this from what is typically feared as “rationing”. Develop the physician role as guide, not gatekeeper—and then make sure the criteria don't call for or encourage gatekeeper-type functions. It is the *relationship* between the doctor and the patient that creates the opportunity for improved stewardship—not an action by either one alone—a gate keeper and a gate crusher—so that productive conversations take place about whether that MRI or knee replacement is needed.
- 11. Which stakeholders have *what influence* in the larger picture of health care home.** The general public (and probably many clinicians, staff, and administrators) probably do not know exactly what each major stakeholder in “medical home” has in their purview by way of leverage or influence on the big interconnected picture. For example, how many people know exactly what leverage or key processes health plans have to influence this picture (and where they have little or none)? People may say they are “payers”, but this is vague compared to things like “standards, certifications, measures, payment methodology, and ability to draw attention together from many provider groups”. A general educational need may exist for lists of “what is in the circle of influence” for providers, health plans, employers/purchasers, policymakers, state agencies, and convening groups, e.g., ICSI—and how taken together they “cover the waterfront”.
- 12. Criteria for “medical home” expressed such that small or large systems have a shot at it.** One repeating pattern in conversations is “*maybe the solo doctor (or two) really is a great medical home in a way that huge systems can't be*”, immediately followed by, “*but I can't imagine they will have the infrastructure for quality reporting (let alone quality) that big systems have*”. This leads to a precaution that health care home criteria should not legislate small or large practices out of business on medical home just by how the criteria are selected or worded. A similar principle arises when the question is asked “*should a medical home have to be a primary care clinic?*” In this case, there is impetus to specify the performance characteristics but not *a priori* disqualify anything other than a primary clinic. A common counter-example cited is for rural settings—the critical access hospital with outpatient functions within it may end up being a medical home.
- 13. Reversing the decreasing number of physicians going into primary care or retiring early.** This issue of financial reimbursement in primary care, training debt, and satisfaction in practice life is flagged by every report as a crucial problem that healthcare home must either solve that must be solved in order for health care home to have a shot at coming into being on a meaningful sustainable scale. This has been flagged as a reimbursement issue and it is—but the state of the art probably will need to go beyond that to include more attention to practice satisfaction and team relationships, a new version of “physician autonomy” and “scope of practice” for other providers, what it means to be a “team leader” or a “physician directed practice”. There are likely issues of evolving

professional identity and relationships in reversing the slide in primary care workforce as well as the reimbursement model.

14. To what extent provider functions in health care home are to be credentialed in some way.

Health care home calls for some relatively new roles, functions and relationships around coordination or managing of care, patient engagement and coaching just to name a few. To what extent should various professionals (e.g. nurse practitioners, physician assistants, nurse specialists, care managers, care coordinators, behavioral health providers, nurses, social workers) be credentialed to do these roles beyond their ordinary credentials? Most of the thinking is to assign responsibilities by role and characteristic and aptitude of individual providers, not automatically by discipline or degree. But as health care home becomes a more mainstream application, this question will arise and is susceptible to “turf wars”. Creating some “state of the art” ways of thinking about this ahead of time may reduce this.

15. Appreciate that culture change is involved in thoroughly adopting a health care home model.

Meaningful adoption isn’t just dropping a new system onto a core set of ideas and habits and identities and assumptions that don’t change. To make a sustainable change toward health care home that doesn’t “snap back” will require understanding the self-limiting assumptions and working agreements from the old way of doing things and explicitly introducing new assumptions and working agreements—many of which will press on old habits or sense of “who I am and what I do”.

Areas of likely culture change include “enshrining” new ways to change such as the role of a QI mechanism as part of routine practice improvement; provider teamwork, scope of practice, identity, and autonomy; standard office practice or “standard work” to maintain reliable practice operations; developing the skills and sensibilities for care coordination and making connections to other parts of the care continuum that are not normally connected that well.

16. Adopting health care home in the context of no more healthcare resources and an economic downturn.

A question that will increasingly be asked is whether healthcare home will require considerable up-front capital investments and ongoing costs that will require infusions of money. The literature clearly suggests that considerable overall healthcare savings are possible through implementing this model, but that does not deal with up-front costs, especially for those with significant infrastructure needs such as EHR or whether in the end the mature health care home ends up being cost neutral or takes resources from other parts of the healthcare system.

17. The place of convening organizations and skills in implementing health care home on a meaningful scale.

A recurrent theme in the literature is the need for multiple-stakeholder dialogue, coalitions, and banding together to avoid the pitfall of just one provider, payer, purchaser, or professional organization trying to implement this on their own without the momentum and cooperation of the rest of the surrounding clinical and economic system. Virtually all of the demonstration projects involve multiple-stakeholder dialogue and convening bodies of one sort or another. As demand for health care homes increases, the need will also increase for expert convening and facilitation skills—which is a skill and art unto itself. That capacity will need to be generalized and not left to chance.

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This attachment contains summaries, abstracts, or paraphrases extracted from a meaningful but manageable sample of major national work in the area of Medical Home.

This is a core body of very recent (all 2008 or 2007) literature review articles, evidence-based white papers, and criteria or demonstration reports that capture most of the major literature along with conclusions and recommendations. This body of thought, evidence, experience and opinion is regarded here as a manageable source from which to create a snapshot of the current state of the art in health care home.

Recall that “state of the art” means *“The highest level of development . . . of a device, technique, or scientific field, achieved at a particular time . . . usually as a result of modern methods. . . the most recent, and therefore considered the best; up-to-the-minute.”* The groups that authored these very recent papers represent aggregate efforts of many of those seriously trying to design, evaluate, implement, and test health care home concepts from clinical, systems, financial, and policy perspectives “in real time” and hence can be considered among the primary or at least most articulate sources of current “state of the art”.

These papers all contain literature reviews of some kind or depth, using many of the same primary references. So rather than going to the much larger body of primary references, this appendix employs these review articles and evidence-based position papers as the core source from which to distill a statement of the national state of the art. Of course there are other papers that could or perhaps should be added to this, and hopefully this will be regarded as an expandable document capable of incorporating new and updated source material as it comes in or becomes even more relevant to include here.

The purpose of this table: To aid comparison of how different national groups and reviewers are currently thinking about medical / health care home. This appendix employs a tabular framework for creating a shared understanding of this sample of what is going on nationally. The leftmost column has to do with how that paper looks at medical home goals, desired outcomes, or problems to be addressed. As columns move toward the right, the content becomes more operational and at the right is more about learnings, results and implications for policy or finance. However, the content of each paper “lays” differently so a standard format is not imposed across all papers.

1. Read across the rows to get quick snapshot of how a particular group or report characterizes its work or findings
2. Read down the columns to get a quick sense of common themes or differences in how groups think about each dimension, moving from goals to more operational and policy

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| | |
|--|----|
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Glossary. To clarify some of the terms used in column headings—remembering that the framework is your servant not your master

| | |
|---|--|
| Goals and ends / problems | The desired end state of affairs or problems that require new end states of affairs |
| Governing principles / operating principles | Precepts, rules, philosophy, beliefs, ethics, that guide choices among alternative ways to reach the end goals and define what you stand for |
| Components / functions | Major design chunks, building blocks, systems, functional capacities |
| Standards / Criteria | Specific performance specifications or functional standards for what it means to be or qualify as a health care home |
| Actions / strategies | Recommended or promising ways to act on the medical home concept or the findings cited in the report |
| Policy / payment considerations | Questions framed or recommendations made regarding policy or payment support for health care home |

Joint Principles of Patient-Centered Medical Home: AAFP, AAP, ACP, AOA (March 2007)

| Regarding goals and ends | Joint principles |
|---|--|
| <p>The Patient-Centered Medical Home (PCMH) is an approach to providing comprehensive primary care for children, youth and adults.</p> <p>The PCMH is a health care setting that facilitates partnerships between individual patients, and their personal physicians, and when appropriate, the patient's family.</p> | <ol style="list-style-type: none"> 1. <u>Personal physician</u>. Each patient has an ongoing relationship with a personal physician trained to provide first contact, continuous and comprehensive care. 2. <u>Physician directed medical practice</u>. The personal physician leads a team of individuals at the practice level who collectively take responsibility for the ongoing care of patients. 3. <u>Whole person orientation</u>. The personal physician is responsible for providing for all the patient's health care needs or taking responsibility for appropriately arranging care with other qualified professionals. This includes care for all stages of life; acute care; chronic care; preventive services; and end of life care. 4. <u>Care is coordinated and/or integrated</u> across all elements of the complex health care system (e.g., subspecialty care, hospitals, home health agencies, nursing homes) and the patient's community (e.g., family, public and private community-based services). Care is facilitated by registries, information technology, health information exchange and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner. 5. <u>Quality and safety</u> are hallmarks of the medical home: <ul style="list-style-type: none"> • Practices advocate for their patients to support the attainment of optimal, patient-centered outcomes that are defined by a care planning process driven by a compassionate, robust partnership between physicians, patients, and the patient's family. • Evidence-based medicine and clinical decision-support tools guide decision making • Physicians in the practice accept accountability for continuous quality improvement through voluntary engagement in performance measurement and improvement. • Patients actively participate in decision-making and feedback is sought to ensure patients' expectations are being met • Information technology is utilized appropriately to support optimal patient care, performance measurement, patient education, and enhanced communication • Practices go through a voluntary recognition process by an appropriate non-governmental entity to demonstrate that they have the capabilities to provide patient centered services consistent with the medical home model. • Patients and families participate in quality improvement activities at the practice level. 6. <u>Enhanced access to care</u> is available through systems such as open scheduling, expanded hours and new options for communication between patients, their personal physician, and practice staff. 7. <u>Payment appropriately recognizes the added value</u> provided to patients who have a patient-centered medical home. The payment structure should be based on the following framework: <ul style="list-style-type: none"> • It should reflect the value of physician and non-physician staff patient-centered care management work that falls outside of the face-to-face visit. • It should pay for services associated with coordination of care both within a given practice and between consultants, ancillary providers, and community resources. • It should support adoption and use of health information technology for quality improvement; • It should support provision of enhanced communication access such as secure e-mail and telephone consultation; • It should recognize the value of physician work associated with remote monitoring of clinical data using technology. • It should allow for separate fee-for-service payments for face-to-face visits. (Payments for care management services that fall outside of the face-to-face visit, as described above, should not result in a reduction in the payments for face-to-face visits). • It should recognize case mix differences in the patient population being treated within the practice. • It should allow physicians to share in savings from reduced hospitalizations associated with physician-guided care management in the office setting. • It should allow for additional payments for achieving measurable and continuous quality improvements. |

Commonwealth Fund: Organizing the U.S. health care delivery system for high performance. The problem of fragmentation (Shih, Davis, Shoenbaum, Gauthier, Nuzum, McCarthy; August 2008)

| Regarding the problem | Regarding solutions: Attributes of ideal system and its organization | Achievability of ideal system / case analyses | Policy recommendations |
|--|--|--|---|
| <p>Health care in US has long been described as a “cottage industry,”</p> <ul style="list-style-type: none"> • Characterized by fragmentation at the national, state, community, and practice levels. • No single national entity or policies guiding the health care system • States divide their responsibilities among multiple agencies • Providers practicing in the same community and caring for the same patients often work independently from one another. • The fragile primary care system is on the verge of collapse. <p>Fragmentation is fundamental to poor performance of care system</p> <ul style="list-style-type: none"> • Patients and families navigate unassisted across different providers and care settings, fostering frustrating and dangerous patient experiences; • Poor communication and lack of clear accountability for a patient among multiple providers lead to medical errors, waste, and duplication; • The absence of peer accountability, quality improvement infrastructure, and clinical information systems foster poor overall quality of care • High-cost, intensive medical intervention is rewarded over higher-value primary care, including preventive medicine and the management of chronic illness. | <p><u>Attributes of ideal delivery system</u></p> <ol style="list-style-type: none"> 1. Patients’ clinically relevant information is available to all providers at point of care and to patients through EHR 2. Patient care is coordinated among multiple providers, and transitions across care settings are actively managed. 3. Providers (including nurses and other members of care teams) both within and across settings have accountability to each other, review each other’s work, and collaborate to reliably deliver high-quality, high-value care. 4. Patients have easy access to appropriate care and information, including after hours; there are multiple points of entry to the system; and providers are culturally competent and responsive to patients’ needs. 5. There is clear accountability for the total care of patients 6. The system is continuously innovating and learning in order to improve the quality, value and patients’ experiences of health care delivery. <p><u>About “organization”</u>: relationships among providers, with established mechanisms for communication or working across providers, settings.</p> <ul style="list-style-type: none"> • Information should flow more easily among providers in an organized system than among unrelated providers. • Organized systems are likely to have more resources and expertise to invest in infrastructure, ranging from health info technology to staff and processes for quality measurement and improvement, and be able to take advantage of economies of scale. • Large organizations can create financial incentives for physicians to improve the quality of care. • In organized systems, physicians and other health care providers should have easy access to colleagues for formal and informal consultation and sharing knowledge. • As part of an organization, providers could hold one another accountable for high-quality care. An organized system has potential to efficiently allocate resources for optimal care • A more organized system should offer multiple points of access to care across the continuum of health services. <p>Literature findings on “organization”:</p> <ul style="list-style-type: none"> • More organization is associated with higher quality; large groups perform better than solo practices • Physicians in group practice do better on recertification tests than those in solo practice • Physician affiliation with networks is associated with higher quality • Full integration may lead to even higher performance • Integrated delivery systems may be more efficient and cost less • Systems that emphasize PC provide better outcomes at lower cost • Prepaid group practices perform worse on patient satisfaction than FFS health plans, but recent works suggests it is possible for large groups to excel • Improving doctor-patient communication, coordination, and access led to improvements in patient experience in those areas • Patients believe in theory that care would improve if physicians practiced in groups. <p>A bibliography of 56 articles are cited in support of all this</p> | <p><u>Four important lessons</u> emerged from examining 15 diverse health care delivery systems widely recognized as examples of high performance:</p> <ol style="list-style-type: none"> 1. Our ideal delivery system is achievable; existing delivery systems have many of the key attributes we have identified. 2. There is more than one way to organize providers to achieve those key attributes, ranging from fully integrated delivery systems and large, multi-specialty group practices to looser forms of organization such as private networks of independent providers (e.g., independent practice associations) and government-facilitated networks of independent providers. <ol style="list-style-type: none"> A. Integrated delivery with providers, hospitals, and a health plan, e.g., Kaiser Permanente, Geisinger, Denver Health, Group Health Coop, HealthPartners, Henry Ford, Intermountain, Marshfield, NYC Health and Hospital Corp, Scott & White (TX) B. Integrated system without health plan, e.g. Mayo Clinic, Partners Health Care (MA), MeritCare (ND) C. Private independent provider networks such as IPA or virtual network, e.g. Hill Physicians group of N CA and North Dakota Rural Cooperative Networks—Northland Healthcare Alliance D. Government facilitated networks of independent providers, e.g. Community Care of North Carolina; Denmark’s universal health insurance system 3. Some form of organization (i.e., established mechanisms for working across providers and settings) is required to achieve these attributes, and is consistent with the literature, which suggests that greater organization is associated with better quality and, to some extent, greater efficiency. 4. Leadership is a critical factor in the success of delivery systems <p><u>The role of retail clinics</u>. At first glance, it may appear they further fragment the delivery system, but not necessarily. Retail clinics, if part of an organized delivery system (e.g., Geisinger’s “Careworks Convenient Healthcare” clinics), can promote easy access to care and greater efficiency. Crucial to coordinate with care delivered by the patient’s larger delivery system, most likely thru a shared electronic medical record system.</p> | <p>Financial, regulatory, professional, and cultural environments act as barriers to organizing health care delivery. Policy recommendations below promote better delivery system organization for gains in quality and value.</p> <p><u>Principles for policy statements</u>:</p> <ol style="list-style-type: none"> 1. Policies should move toward achievement of the attributes of the ideal delivery system we have identified. 2. The policies should allow for diverse models of organization to achieve these attributes, recognizing that different regions of the country may require different arrangements. 3. No single policy will fix the fragmentation of our health care system. Rather, a comprehensive approach is required—one that might lead progressively to greater organization and better performance. <p>Policy strategies:</p> <ol style="list-style-type: none"> 1. <u>Payment reform</u>. The opportunity to stimulate greater organization as well as higher performance. The FFS system fuels the fragmentation of our delivery system. We recommend that payers move away from FFS toward bundled payment systems that reward coordinated, high-value care. <ul style="list-style-type: none"> • The more organization in delivery systems, the more feasible payment reforms become. Payment reforms spur organization, rewarding optimal care over the continuum of services. • Specifically, full population prepayment—a single payment for the full continuum of services for a given patient population and period of time—should be encouraged, and should be adequately risk-adjusted to avoid adverse patient selection. <p>If full population prepayment is not feasible, payers should encourage:</p> <ul style="list-style-type: none"> • Global case payments for acute hospitalizations, ideally bundling all related medical services from initial hospitalization to a defined period post-hospitalization (including preventable rehospitalizations), and should be risk-adjusted to avoid adverse patient selection. • Alternative payment structures for primary care practices that provide comprehensive, coordinated, patient-centered care (e.g., certified medical homes), as an alternative to FFS. e.g. comprehensive prepayment for primary care services or fee-for-service payments plus a per-patient care management fee. • Expand pay-for-performance, with the more bundled the payment mechanism, the higher proportion of the payment tied to performance. Migrate away from measures that focus on individual processes in a single provider setting (e.g., hemoglobin A1C testing rates for patients with diabetes) toward broader quality measures such as clinical outcomes (e.g., BP control or hospital readmission rates), care coordination, patient experiences. • Medicare should support further demonstration projects that test innovations in payment design and care delivery. 2. <u>Patient incentives</u> to choose to receive care from high-quality, high-value delivery systems. This requires performance measurement systems that adequately distinguish among delivery systems. 3. <u>Regulatory changes</u> to facilitate clinical integration among providers. 4. <u>Accreditation</u> of programs that focus on the six attributes of an ideal delivery system identified. Encourage payers and consumers to base decisions on payment and provider networks on such information, in tandem with performance measurement data. 5. <u>Provider training</u> to teach systems-based skills and competencies, including population health, and clinical training in organized delivery systems. 6. <u>Government infrastructure support</u>. Certain regions or for specific populations, formal organized delivery systems may not develop on their own. In such instances, the government play a greater role in facilitating or establishing the infrastructure for an organized delivery system, for example through assistance in establishing care coordination networks, care management services, after-hours coverage, health information technology, and performance improvement activities. 7. <u>Health information technology</u>. Require providers within 5 years to implement and utilize certified electronic health records that meet functionality, interoperability, and security standards, and to participate in health information exchange across providers and care settings. |

Institute for Clinical Systems Improvement
Health Care Home State of the Art: National Literature framework. 12/30/08

National Quality Forum—National Priorities Partnership (11/08). National Priorities and Goals: Aligning Our Efforts to Transform America’s Healthcare. Washington, DC

(Report of a collaboration of 28 national organizations convened by NQF: IHI, NCQA, Leapfrog Group, Am Bd of Medical Specialties, The Joint Commission, NQF, Natl Business Group on Health, Consumers Union, IOM, CDC, Am Health Insurance Plans, Alliance for Pediatric Quality, Brookings Institution, NIH, Natl Partnership for Women & Families, AQA, Cert Commission for HIT, Physician Consortium for Perf Impr, AARP, Natl Governor’s Assoc, AFL-CIO, Natl Assn of Comm Health Ctrs, ANA, Hosp Quality Alliance, US Chamber of Commerce)

| Regarding national goals, priorities, measures | Change process and drivers envisioned |
|--|--|
| <p>Address 4 major challenges: 1) Eliminating harm, 2) Eradicating disparities, 3) Reducing disease burden, 4) Removing waste.</p> <p>Six priority areas are identified where collective efforts can have the most impact. The goals under them are aspirational—intended as guides to many small-scale improvement projects that will offer direction on how to bring to scale nationally. Each goal is stated as something the Partners will work together to ensure, and comes with a significant bibliography and demonstration examples to back up each point.</p> <ol style="list-style-type: none"> Engage patients and families in managing their health and making decisions about their care. Healthcare that honors each patient and family, offering voice, control, choice, skills in self-care, transparency; adapted readily to individual and family circumstances, and differing cultures, languages and social backgrounds. <ul style="list-style-type: none"> • Pts asked for feedback on experience of care, which healthcare organizations and their staff will use to improve care. • Pts have access to tools and support systems that enable them to effectively navigate and manage their care. • Pts have access to information and assistance that enables them to make informed decisions about their treatment options. Improve health of the population. Communities that foster health and wellness; national, state, local systems of care fully invested in prevention of disease, injury, and disability—reliable, effective, and proactive in helping all people reduce the risk and burden of disease. <ul style="list-style-type: none"> • All Americans to receive the most effective preventive services recommended by the U.S. Preventive Services Task Force. • All Americans will adopt the most important healthy lifestyle behaviors known to promote health. • The health of American communities will be improved according to a national index of health. Improve safety and reliability of America’s healthcare system. Relentless in continually reducing risks of injury from care, aiming for “zero” harm—absolutely reliable care, guaranteeing that every pt, every time, receives benefits of care based solidly in science. Healthcare leaders and professionals intolerant of defects or errors; constantly seek to improve, regardless of current safety & reliability. <ul style="list-style-type: none"> • Ensure culture of safety while lowering incidence of healthcare-induced harm, disability, or death toward zero; continually reducing & seeking to eliminate healthcare-associated infections (HAI) and serious adverse events, e.g. surgical and catheter-associated infections, ventilator assoc pneumonia, pressure ulcers, falls, wrong site surgeries, foreign objects, air embolisms, adverse drug events • Hospitals reduce preventable and premature hospital-level mortality rates to best in class • Hospitals and community partners improve 30-day mortality rates following hospitalization for select conditions to best in class Ensure patients receive well-coordinated care within and across all healthcare organizations, settings, and levels of care. A system that guides patients and families through their healthcare experience, while respecting patient choice, offering physical & psychological supports, and encouraging strong relationships between patients and the healthcare professionals. <ul style="list-style-type: none"> • Healthcare organizations and their staff to continually strive to improve care by soliciting and carefully considering feedback from all patients (and their families when appropriate) regarding coordination of their care during transitions. • Medication information will be clearly communicated to patients, family members, and the next healthcare professional and/or organization of care, and medications will be reconfirmed each time a patient experiences a transition in care. • All healthcare organizations and their staff will work collaboratively with patients to reduce 30-day readmission rates. • All healthcare organizations and their staff will work collaboratively with patients to reduce preventable emergency department visits. Guarantee appropriate and compassionate care for patients with life-limiting illnesses. Healthcare promising dignity, comfort, companionship, and spiritual support to patients and families facing advanced illness or dying, in synchrony with all the resources that community, friends, and family can bring to bear at the end of life. <ul style="list-style-type: none"> • Access to effective tx for relief of suffering from sx such as pain, SOB, weight loss, weakness, nausea, serious bowel problems, delirium, and depression. • Access to help with psychological, social, and spiritual needs. • Effective communication from healthcare professionals about options for treatment; realistic information about their prognosis; timely, clear, and honest answers to their questions; advance directives; and a commitment not to abandon them regardless of their choices over the course of their illness. • High-quality palliative care and hospice services. Eliminate overuse while ensuring the delivery of appropriate care. Healthcare that promotes better health and more affordable care by continually and safely reducing the burden of unscientific, inappropriate, and excessive care, including tests, drugs, procedures, visits, and hospital stays. <ul style="list-style-type: none"> • All healthcare organizations will continually strive to improve the delivery of appropriate patient care, and substantially and measurably reduce extraneous service(s) and/or treatment(s). • Areas of concentration and targets: Inappropriate med use, lab tests, maternity interventions, dx procedures, non-palliative services at EOL, surgical procedures, consultations, ED visits and admissions, potentially harmful preventive services with no benefit. (Specific targets are listed for each of these categories) | <p>Plans: A starter set of National Priorities is only first step. Over next year and beyond, these hopefully will spur coordinated action and innovation. The Partners agreed to work with each other and with policymakers, healthcare leaders, & community to build on framework provided and develop actions in each major area.</p> <p>Drivers of transformation</p> <ol style="list-style-type: none"> Performance measurement—harmonized and consistently applied measures across settings; parsimonious; intrinsic meaning, balance QI with stability needed to track over time Public reporting—meaningful to consumers; diverse array of goals; involvement of those measured; transparent and valid; based on national standards Payment systems—not volume only; tied to results; fostering good care and stewardship; supporting coordination & integration; simple and understandable; right incentives for patients; balance both innovation and EBM Research & knowledge dissemination—evidence for what to do is variable so the national goals should inform the research agenda, particularly translational Professional development: Education & Certification on—providing pt-centered care; working in interdisc. teams; EB practice; applying QI methods; using informatics System capacity—away from “fragmented and dysfunctional: HIT; clinical knowledge management; care process design; interdisciplinary teams for chronic care; coordination of care across diseases and settings; performance measurement <p><u>Guideposts for transformation:</u></p> <ol style="list-style-type: none"> Listening to patients and families—direct, standardized measure of “patient voice” regarding experience of care Organizing around the patient’s journey <ul style="list-style-type: none"> • Focus on continuum of care, not just individual prov. perf. • Outcomes desired by pts in addition to desired care processes • Measures of efficiency along w outcomes & experience of care Engage all stakeholders—including patients themselves <ul style="list-style-type: none"> • Emphasize local improvement as well as external assessment • Engage all providers, no matter current level of achievement <p>(Report does not talk specifically about “medical home”)</p> |

The Medical Home: Disruptive Innovation for a New Primary Care Model. The Deloitte Center for Health Solutions (2008)

| Regarding goals & principles | Regarding features / functions | Regarding payment models / ROI analysis | Moving forward |
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| <p>Goals: To provide a patient with a broad spectrum of care, both preventive and curative, over a period of time and to coordinate all of the care the patient receives.</p> <p>Burning platform:</p> <ul style="list-style-type: none"> Chronic illness care PC workforce shortage Overall healthcare costs <p>Governing principles: A “medical home” is not a house, hospital or other building. Rather, a term used to describe a health care model in which individuals use PC practices as basis for accessible, continuous, comprehensive, integrated care.</p> <ul style="list-style-type: none"> An extension of the Wagner chronic care model Embraces joint principles for medical home (AAFP, AAP, ACP, AOA) Caremgmt in the PC clinic, with contact with personal physician rather than through distant care or disease mgmt entities and staff. | <p>Critical features of the medical home: A platform for guided self-management</p> <ol style="list-style-type: none"> <u>Personal physician</u>: Each patient has ongoing relationship with a PCP and clinician health coaches trained to provide first-contact, continuous, comprehensive care. These clinicians are competent in active listening, health coaching, evidence-based holistic medicine, clinical information technology, population-based outcome improvement and measurement, care team recruitment and leadership. <u>Physician-directed primary care professional organization</u>: A physician leads team of health coaches who collectively take responsibility for the ongoing care of patients. Day-to-day operation focused on managing to population-based outcomes and maximizing individual patient adherence to customized self-care mgmt program that leverages info technology. A health coach is an allied professional (nurse/patient educator) with specialized training in pt behavior modification & motivational interviewing to match patient values, preferences and triggers to specific, measurable, short-term, self-care lifestyle modifications. <u>“Whole person” orientation toward adherence (not compliance), incorporating holistic methods with conventional allopathic interventions</u>: PC team responsible for providing all the patient’s healthcare needs and arranging care with other qualified professionals in care for all stages of life: acute care, chronic care, preventive svcs, end-of-life care, with strong consideration of individual’s value system, personal preferences and level of engagement in decision making. Dispensation of directives (prompts, alerts, reminders) in teachable moments to patients and family members/significant influencers to expedite adherence to self-care suggestions (not just compliance to directives). Holistic therapeutic interventions, such as mindful daily practices, are integrated with traditional therapeutic interventions. <u>Monitored, coordinated and integrated care using electronic medical records and personal health records</u>: Care is facilitated across all elements of the complex health system (e.g., subspecialty care, hospitals, home health agencies, nursing homes) and the patient’s community (e.g., family, public and private community-based services) by registries, health info exchanges, and other electronic means to assure that patients get the indicated care when and where they need and want it, in a culturally and linguistically appropriate manner. Information exchanges among members of the patient’s care team are synchronized and real-time and are also used to reduce unnecessary visits, tests and referrals. Sharing info among medical homes and other providers in the local and regional care system is indicative of an advanced medical home model. <u>Measured and managed adherence to evidence-based practices by the care team and the patient</u>: Results measures are hallmarks of medical home: Processes and outcomes to patient satisfaction and success rates in changing behavior: <ul style="list-style-type: none"> EBM and decision-support tools guide decision-making. Non-adherence by care team and/or pt is monitored and measured, and root-cause analysis to assess errors and near-misses. Physicians accept accountability for continuous QI by voluntarily perf measurement & improv. Patients actively participate in decision-making; fb to ensure patients’ expectations being met. Info technology used to appropriately support optimal patient care, performance measurement, patient education, and enhanced communication. Patients and families participate in quality improvement activities at the practice level. <u>Enhanced accessibility: care anywhere, anytime</u>: Care available via open scheduling, expanded hours, new communications options among patients, physicians and practice staff. Innovations such as group visits, cyber-visits, customized educational tools and self-monitoring devices available thru the practice. <u>Emphasis on physician incentives for improvements in self-care management</u> (see next column) | <p>Emphasize physician incentives for improvements in self-care management: Reimbursements to recognize added value to pts and should:</p> <ul style="list-style-type: none"> Reflect the value of patient-centered care management work that falls outside of the face-to-face visit. Pay for services associated with care coordination within a given practice and among consultants, ancillary providers, community resources. Support adoption and use of health information technology for quality improvement. Support enhanced communication access such as secure e-mail and telephone consultation. Recognize the value of technology-based physician work associated with remote monitoring of clinical data. Allow for separate fee-for-service payments for face-to-face visits. Recognize case mix differences in the patient population being treated within the practice. Allow physicians to share in savings from reduced hospitalizations assoc with physician-guided care mgmt in office setting. Allow additional payments for achieving measurable and continuous quality improvements. <p>Incremental cost of medical home. Deloitte analysis predicts systemic application would need to reduce annual net health costs by at least \$148k to \$163k per PC physician to break even. For a panel of 1,000 pts needing care coordination, net costs for health services must be reduced by at least \$150 per pt / mo to break even—plausible, considering potential avoidance of costly hospital admissions, emergency room visits and related services.</p> <p>Deloitte systemic model to assess ROI</p> <p><u>Assumptions:</u></p> <ul style="list-style-type: none"> Prevalence for CHF, diabetes, asthma/COPD, hypertension of 0.2%, 5 %, 3.2%, and 25% respectively 0% growth in future chronic symptom prevalence to be conservative, and models only most prevalent chronic conditions. More savings would accrue if additional conditions included. Disease mgmt experience assumptions used because there is no documented ROI for medical home: <ul style="list-style-type: none"> -15% enrollment of eligible chronic illness patients—(more by half in future state medical home) -75% of eligible pts are actionable at any given time—outreach taking place to improve health -Health coach can manage 250 pts on average -Incremental costs per panel: \$78k per health coach; \$40k for health coach tools; \$100k per physician for care coordination; \$23k for 1/3 FTE data mgr; \$5-\$20k health info tech -150,000 new medical homes (to multiply costs above); Non-medical cost inflation: 4% -Additional \$100k care mgmt revenue to offset \$100k increase in physician care mgmt cost Impact from reduced utilization of all kinds: <ul style="list-style-type: none"> -Care coordination/disease mgmt: 30% savings to inpatient and phys reimbursement, 10% fewer admissions, 20% fewer ED visits, 10% less absenteeism -Traditional disease mgmt results are mixed. Deloitte assumes \$170 / mo per pt enrolled in disease mgmt <p><u>Implications of medical home for stakeholders</u> (more detailed stakeholder implications included in report)</p> <ul style="list-style-type: none"> Individual PCP: <ul style="list-style-type: none"> -One-time investment of \$100k plus ongoing expense of \$150k or more. -Strategic partner with up front capital to help operationalize; long-term bonus structure -Revamp practice operations to focus on care coordination and adherence rather than visits -Risk could be high relative to return unless part of a community-based care mgmt model and collab among local payors and health info exchange Hospital with substantial PC network <ul style="list-style-type: none"> -10% fewer admission; 20% fewer ED visits -Reduced volumes to community-based specialists thru care coordination—could affect relationships -Make sure medical home efforts make strategic sense to hospital stakeholders, including community Commercial health plan <ul style="list-style-type: none"> -Potential to shift costs from acute to preventive & chronic care over time. But could be unsettling in community if sponsored by only 1 plan -But could be a positive, disruptive strategy in a community where a plan wishes to provide value added to a group of large employers -Because physicians tend to distrust health plans, consider a onus structure tied to population outcomes and cost savings Public payer (similar to commercial health plans) <ul style="list-style-type: none"> -Shifting industry from reactive / acute reimbursement to prevention and care coordination -Much leverage in the CMS Medicare Medical Home demonstration | <p>Challenges:</p> <ul style="list-style-type: none"> Physician training—care coord systems Policy—who / how responsible for results PC workforce shortage Industry structures—to scale up nationally Physician lack capital and incentives to invest up front Turf wars among care manager vendors / health plans Financial savings still questionable—“proof” not yet available. <p>Compelling arguments:</p> <ul style="list-style-type: none"> A better delivery model and patient relationship model Care mgmt/adherence reinforces EBM Physicians could partner with care mgmt vendors / hosp for economies of scale Realigned financial incentives address overuse-underuse Medical homes can pay for themselves Better clinical & financial outcomes for more productive & competitive workplace in global economy |

Patient-Centered Primary Care Collaborative: The Patient-Centered Medical Home—A purchaser guide (2008). Developed by the National Business Coalition on Health through grant from the PCPCC Center for Health Benefit Redesign and Implementation

| Purpose, problem, why purchasers should support medical home | Principles: | Research on effectiveness of Medical Home | Purchaser actions to support Medical Home | Purchaser-involved demonstr. |
|---|--|---|---|---|
| <p>Purpose of report:</p> <ul style="list-style-type: none"> Overview of Patient-Centered Medical Home, why purchasers should consider supporting it. Strategies, supplemental resources, detailed case study descriptions, additional info on pilots, draft RFI / contract language for purchasers. <p>Why purchasers should support the patient-centered medical home concept:</p> <p>1. <u>The Magnitude of the Problem.</u> Purchasers have struggled with the problem for years.</p> <ul style="list-style-type: none"> Americans receive only about half of the recommended, evidence-based care they require when they see their doctor. (McGlynn et al, 2003) Between 20% and 50% of U.S. health care spending produces no benefit to the patient—and some produces harm (Wennberg et al, 2002). At a mid-point (30%) the waste totals \$700B annually. (Brownlee, 2007) The US spends more on health care per capita than any other country (WHO, 2004), yet performs inconsistently across states, and poorly when compared with industrialized countries (Commonwealth Fund, 2006). Preventable admissions for diabetes, CHF, asthma were twice level achieved by the top states; gap between national average rates of diabetes and blood pressure control and rates achieved by the top 10% of health plans translates into estimated 20,000 to 40,000 preventable deaths and 1 to \$2 billion in avoidable medical costs. High and growing health care costs harm employers. High costs of health care harms competitiveness of American employers (Nicols & Axen, 2008). High and growing health care costs harm employees. Employers have increased cost sharing which can engender more thoughtful use by employees but also creates barrier to necessary care for lower income workers and adds a financial burden. More than a quarter of Americans report a serious problem paying for health care and insurance. (Kaiser Family Foundation, 2008) <p>2. <u>The Role of Purchasers in Improving Health Care.</u> Employment-based coverage is the most prominent form of health insurance in the US. Whatever actions purchasers take—including no new action—will directly influence health care delivery. It is important that employer purchasers evaluate the business case for the medical home and decide whether and how to incorporate medical home into purchasing strategies—to create insurance product design & performance requirements that align incentives with improved quality and efficiency, and engage providers in joint efforts to transform care delivery.</p> <p>3. <u>Decline of Primary Care.</u></p> <ul style="list-style-type: none"> Many employers hear about the increasing challenge for employees and dependents to find a PC practice that will accept new patients. When able to see PC physician, the experience is too often poor for both patient & physician. Physician workforce is heavily weighted toward specialty care. US graduates entering family medicine residencies dropped by 50% between 1997 and 2005 (Bodenheimer, 2008). Payment reform needed. Diagnostic, surgical, imaging procedures often pay 3 times as much as same time with patient with diabetes, heart failure, headache, depression. Income of specialists in 2004 almost twice that of PC physicians and widening (Bodenheimer, 2008) <p>4. <u>Status quo is not the answer.</u> Some adherents of Patient-Centered Medical Home are convinced that the model will deliver superior performance, but many supporting application of the concept do so realizing that there is a risk that this might not be the case. These purchasers and payers, however, find the merits sufficiently compelling to warrant investment in pilots or phased implementations subject to formal evaluation. For them, the definition of insanity is doing the same thing over and over again and expecting a different result, and they are compelled to explore new approaches that offer reasonable likelihood of success.</p> | <p>The Joint principles of the Patient-Centered Medical Home (AAFP, ACP, AAP, AOA, 2007)</p> <p>Wagner Care Model</p> <p>Care coord / case mgmt: A proactive PC practice-based function done by members of the PC team and often not by a physician (in contrast to distant disease mgmt services)</p> <p>Employer / purchaser involvement in healthcare redesign</p> | <p>Effectiveness research evaluating the impact of patient affiliation with a PC practice on patient health and expenditures, and research to evaluate the Chronic Care Model suggests that increased adoption of the Patient-Centered Medical Home (and increased use of it by patients), should yield significant measurable benefits.</p> <p>1. <u>Primary Care Practice Orientation findings.</u> B. Starfield and others have researched impact of a PC-oriented care system on outcomes, costs, and equity. Starfield has found that greater orientation towards PC results in lower costs and better outcomes. Conversely, a specialist-oriented system (like in U.S.) is associated with higher costs and poorer outcomes. Adequate access to primary care provides health and economic benefits (Phillips & Starfield, 2004)</p> <ul style="list-style-type: none"> Reduced all-cause mortality & mortality by cardiovascular & pulmonary diseases Less use of emergency departments and hospitals Better preventive care Better detection of breast CA; reduced incidence & mortality from colon & cervical CA Fewer tests, higher patient satis., less medication use, and lower care-related costs Reduced health disparities, particularly for areas with highest income inequality, including improved vision, immunization, BP control, oral health PC-oriented health care results in increased patient satisfaction <p>2. <u>Chronic Care Model findings.</u> The Chronic Care Model (Wagner) focuses on how PC practice can restructure / reorient for improved clinical care. Research on application of Chronic Care Model elements is at www.improvingchroniccare.org, and research funded by Robert Wood Johnson Foundation and performed by RAND and UC at Berkeley on three Chronic Care Model collaboratives (http://rand.org/health).</p> <p>While findings have varied from study to study, studies have generally found that the application of elements of the Chronic Care Model improves quality and health status and reduces costs. One effort to combine information on the Chronic Care Model from 112 different studies to derive an overall estimate of a treatment's effect (meta analysis, Tasi et al, 2005) yielded this: interventions with one or more elements of the CCM improve clinical outcomes and processes for patients with chronic illness, and multi-faceted interventions incorporating multiple elements of the Chronic Care Model have greater impact on outcomes than single or simpler interventions incorporating a more limited number of model elements.</p> <p>A second study (Bodenheimer et al, 2002) focused on cost impact and found:</p> <ul style="list-style-type: none"> CHF studies: 3 positive for reduced use/costs; 2 negative for reduced use/costs Asthma: 8 positive for reduced health care use/costs; 5 negative for reduced use/costs Diabetes studies: 7 positive for reduced health care use/costs; 2 negative for reduced use/costs Savings are achievable through reduced inpatient days and fewer ER visits. Targeting higher risk patients results in more significant cost improvements. Cost benefits of temporary programs may be short-lived. Financial savings require aligned incentives; a favorable business case means savings must accrue to the same organization paying for chronic care improvements. <p><u>This research should assure employer purchasers who feel understandable caution about investing in a new concept such as PCMH that the concept is, to a considerable degree proven (plentiful research on core elements that demonstrate effectiveness with cost & quality) even though there is no research on effectiveness of the PCMH as specifically defined by the PCPCC Joint Principles or NCQA PPC-PCMH recognition standards.</u></p> | <p>Six purchaser strategies (to be pursued independently and/or in concert with other purchasers in a coalition):</p> <ol style="list-style-type: none"> <u>Participate in a regional pilot(s)</u> <ul style="list-style-type: none"> Encourage contracted insurers to participate in a multi-payer pilot Encourage your purchaser coalition to adopt a position supporting PCMH Sponsor a PCMH pilot Identify criteria that must be met for purchaser support of a pilot Participate in the pilot design process <u>Incorporate PCMH into insurer procurement & performance assessment</u> <ul style="list-style-type: none"> New questions in RFI's, RFP's Measure insurer performance on PCMH <u>Align payment strategy</u> with PCMH adoption <ul style="list-style-type: none"> Provide financial support / incentives in support of PCMH to insurers and/or PC practices Promote alignment of performance incentive programs across insurers <u>Build coalitions in support of PCMH</u> <ul style="list-style-type: none"> Educate, advocate, increase awareness Convene, facilitate multi-stakeholder efforts with insurers, employers, providers, labor Approach a respected organization to convene & facilitate multi-stakeholder effort Partner with states as convener Work directly with provider community about working together for PCMH <u>Engage consumers</u> <ul style="list-style-type: none"> Educate employees about medical home concept and benefits Incentives for employees to choose services that support good PC and self-care or are PCMH homes Incentives for employees to adhere to evidence based care, e.g. well care visits, screening, self-care plans <u>Integrate PCMH into corporate health strategies.</u> <ul style="list-style-type: none"> Coordinate employer-contracted carve-out services with PCMH, e.g., disease mgmt, pharmacy, behavioral health Coordinate employer-contracted non-health benefit services with PCMH, e.g. EAP, health & wellness Integrate worksite wellness into medical home activity Make employer on-site clinics are PCMH-oriented <p>This report includes many sample devices, language, metrics and sub-strategies.</p> | <p>Community Care of North Carolina <u>Start:</u> 1998 <u>Population:</u> Medicaid <u>Results:</u> Comparing what the program would have cost in SFY04 without any concerted efforts to control costs in SFY04, program saved ~ \$124 M</p> <p>Horizon BCBS of New Jersey / Partners in Care <u>Start:</u> 2007 <u>Population:</u> State employees & dependents with diabetes <u>Results:</u> Pts in the one-year pilot program substantially increased compliance with several key evidence-based care measures both specific and non-specific to diabetes. Preliminary results also indicated medical cost reductions.</p> <p>Pennsylvania Chronic Care Initiative <u>Start:</u> 2008 <u>Population:</u> Medicaid, state employees—for PCMH and Chronic Care Model <u>Methods:</u> Chronic care model components, Level 1 NCQA recog., insurer support of learner session costs, State support of collaborative <u>Results:</u> Not yet evaluated</p> <p>THINC RHIO Pay-for-Perf / Medical Home Project (Hudson River Valley region of NY) <u>Start:</u> 2009 <u>Method:</u> Recruit 250 practices. If NCQA recognized, eligible for enhanced payments based on structural factors. Multiple insurers, IBM, Hannaford Brothers <u>Results:</u> Not yet implemented</p> <p>Colorado Multi-Payer Demonstration <u>Start date:</u> 2007 <u>Purchasers:</u> Colo Business Group on Health and member employers <u>Method:</u> Broad, multi-stakeholder PCMH 2-yr pilot in front range region. Practices to become NCQA-recog. with enhanced payment system</p> |

Behavioral Health / Primary Care Integration and the Person-Centered Healthcare Home—a discussion draft. National Council for Community Behavioral Healthcare (NCCBH, 10/08). Summarized / paraphrased by permission from B. Mauer)

| Regarding goals & principles | Behavioral health as part of the full scope person-centered healthcare home | Partnership between BehH and PC providers | Policy & practice issues |
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| <p>Problem: People living with serious mental illnesses die 25 yrs earlier than rest of population, in large part due to unmanaged physical health conditions. Depression and anxiety are significantly comorbid with chronic health conditions seen in PC</p> <p>Goal of report: To address the gap in current thinking about this health disparity</p> <ul style="list-style-type: none"> Bring together current developments in the patient-centered medical home with evidence-based approaches to integration of PC and behavioral health. Evidence-based approaches to person-centered healthcare home for the population living with serious MI. Expand national medical home dialogue to incorporate lessons of IMPACT model Signal the need for behavioral healthcare services in PC settings What does a medical home look like for people with serious mental illnesses? <p>Principles:</p> <ul style="list-style-type: none"> Anchored in Joint Principles of the Patient Centered Medical Home (AAFP, AAP, ACP, AOA) Anchored in core components of IMPACT model for treating depression in PC (see third column) and emerging research on delivering primary care services in BehH settings. Unlike disease mgmt models by phone from distant places or health plans, care manager is embedded in the clinical team | <p>The Case for Behavioral Health as Part of the Medical Home After the initial Quality Chasm report, IOM embraced the Aims and Rules for mental and substance-use conditions, and made two overarching recommendations:</p> <ul style="list-style-type: none"> Healthcare for general, mental, & substance-use problems must be delivered with understanding of the inherent interactions between mind/brain and rest of the body The aims, rules, and strategies for redesign in Quality Chasm should be applied throughout mental/substance use healthcare but tailored to characteristics that distinguish care for these problems and illnesses from general health care. <p>IMPACT model as a pattern for Medical Home. The national dialogue regarding patient-centered medical home should incorporate the lessons of the IMPACT model—explicitly building in the care manager / behavioral health consultant and consulting psychiatrist as part of the medical home team.</p> <p>IMPACT: Unutzer and his colleagues followed 1,801 depressed, older adults in 18 diverse PC clinics across the US for 2 years, utilizing care management within a stepped care approach. In Minnesota, the DIAMOND initiative follows similar pattern:</p> <ul style="list-style-type: none"> Collaborative care: The person’s PC physician works with a care manager/ behavioral health consultant to develop and implement a treatment plan. The care manager/behavioral health consultant and primary care provider consult with a psychiatrist to change the treatment plan if individual does not improve. Care manager/behavioral health consultant who may be supported by an MA. Unlike disease mgmt models, care manager is embedded in the clinical team A designated psychiatrist who consults to the care manager/behavioral health consultant and PCP on persons who do not respond to tx as expected Outcome measurement and registry tracking thru care managers Stepped care in which tx is adjusted depending on outcomes. <p>IMPACT findings: Doubled the effectiveness of care for depression, benefited various populations, improved physical functioning and pain for participants, lowered healthcare costs.</p> <p>Rename “patient-centered medical home” to “person-centered healthcare home” to signal that BehH is a central part of healthcare and includes supporting a person’s capacity to set goals for improved self-mgmt. A person-centered healthcare home would accept 24/7 accountability for a population and include:</p> <ul style="list-style-type: none"> Preventive screening/health services Acute primary care Women and children’s health Behavioral health Management of chronic health conditions End of life care <p>These services are supported by enabling services*, electronic health records, registries, and access to lab, x-ray, medical/surgical specialties and hospital care. This capacity is referred to as a “full-scope healthcare home”.</p> <p>* Enabling services are non-medical services that facilitate access to timely appropriate medical care, incl transportation, language assistance, community outreach & education—ancillary to the care management task of monitoring health status and calibrating care for an individual.</p> <p>The person-centered healthcare home should be implemented bi-directionally. The National Association of State Mental Health Program Directors (NASMHPD) found that 3 of every 5 persons with serious mental illnesses die due to a preventable health condition and that people with serious mental illnesses are dying 25 years earlier than the rest of the population</p> <ul style="list-style-type: none"> Identify people in primary care with behavioral health conditions and serve them there unless they need stepped specialty behavioral healthcare and, Identify and serve people in behavioral healthcare settings that need routine primary care and step them to a full-scope healthcare home for more complex care. <p>Example of a full-scope person-centered healthcare home: Cherokee Health Systems (Tennessee)</p> <ul style="list-style-type: none"> Both a primary care provider and a specialty behavioral health provider Integrated care is at the center of the organization’s vision and mission; practiced across comprehensive primary care, behavioral health, and prevention programs*. Integrated structurally and financially, which supports the focus on clinical integration. A behavioral health consultant is an embedded, full-time member of the PC team, providing brief, targeted, real-time interventions for psychosocial needs and concerns in the PC setting A psychiatrist is also available, generally by telephone, for medication consultation. The BehH consultant provides brief, targeted, real-time interventions in PC Hires PC providers who are comfortable with MH issues and believes that all front-line, administrative and support staff are essential and must be committed to the holistic approach Local community is aware that people are treated for all types of illnesses at Cherokee, and MH consumers find that all are treated in the same way, reducing stigma of seeking MH tx <p>*Just placing BehH and PC functions under same organizational structure or physical facility is co-location, not necessarily collaborative care. Similarly, placing all of the funding into a single budget will not alone result in co-location, much less clinical collaboration. The focus upon the clinical process creates collaborative care.</p> | <p>Partnerships between PC and BehH providers can improve care and local problem solving, even without unified systems like Cherokee.</p> <p>Components of partnership between a BehH organization and a primary care, full-scope healthcare home:</p> <ol style="list-style-type: none"> Regular screening and registry tracking/outcome measurement at the time of psychiatric visits BehH provider in PC team, backup psychiatric consult. Medical nurse practitioners/primary care physicians located in behavioral health Bidirectional partnership (2 & 3 above—and see col 2) A primary care supervising physician An embedded nurse care manager Evidence-based practices to improve the health status of the population with serious mental illnesses Wellness programs <p>Examples and references are given for each of these.</p> <p>The NCCBH Four-Quadrant Model: A population-based planning model for clinical integration</p> <p>This is a conceptual framework or way of thinking about to how to address the needs of population subsets in a local system, or person-centered healthcare home.</p> <p>Q1 subset: Low to moderate BehH and low to moderate physical health complexity/risk. Model: PC team that includes a BehH consultant/care manager, psychiatric consultant, screening for BehH concerns, stepped care.</p> <p>Q2 subset: Moderate to high BehH and low to moderate physical health complexity/risk. Model: PC capacity in a BehH setting, including medical NP / PC physician, wellness, screening for health concerns, stepped care to full-scope healthcare home, access to specialty BehH services to support recovery.</p> <p>Q3 subset: Low to moderate BehH and moderate to high physical health complexity/risk. Model: PC team that includes a behavioral health consultant/care manager, psychiatric consultant, screening for BehH concerns, stepped care, and access to specialty medical/surgical consultation and care management.</p> <p>Q4 subset: Moderate to high BehH and moderate to high physical health complexity/risk. Model: PC capacity in BehH setting, incl medical NP / PC physician, nurse care mgr, wellness, screening/tracking for health concerns, stepped care to a full-scope healthcare home, access to specialty BehH to support recovery, access to specialty medical/surgical consultation & care mgmt</p> | <p>Moving person-centered healthcare homes forward requires:</p> <ul style="list-style-type: none"> Thoughtful, deliberate, adaptive leadership at every level, Across clinical disciplines and the sectors that segment how people are served, How delivery of their care is organized, how communication occurs, and How care is reimbursed. <ol style="list-style-type: none"> Financing methods: Care managers / BehH consultants and psychiatric consultation in PC have not been reimbursable, despite researched models. Exception is DIAMOND Project in MN, “the first depression treatment program in the nation to integrate a collaborative care model with an effective, sustainable reimbursement structure”. Policies seldom encourage and support collaborative practice, and frequently act as barriers, particularly state regulations on BehH treatment planning and documentation that results in time-consuming paper and work processes that are not a good match to the pace of PC Workforce skills needed to work on an integrated team are not generally part of academic training for clinicians; success of person-centered healthcare homes will depend on bridging cultural differences between PC & BehH clinicians. Requires attention in clinical training programs Clinical info sharing for care collaboration is permitted use under HIPAA, except HIV status and receipt of SA tx. Evolving EHR for BehH and PC do not easily intersect; some EHRs for BehH do not have data fields for health status and services to people with serious MI. Physical facilities. Integrated care models rely on teams working in close physical proximity—difficult in facilities fully occupied when integration initiative begins. Space and capital for exam rooms with tables and equipment that PCPs expect in Beh H facilities / settings Research must be informed by, and help inform, evolving models—from traditional “top down” design to partnerships to develop and evaluate working models. |

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|--|--|--|---------------------------|
| | | | evaluate evolving models. |
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NY Medical Home Evidence Policy Statement: “Advancing Medical Homes: Evidence-based literature review to inform health policy. 11/07 NYS Primary Care Coalition (CHC Assoc, PC Devel. Corp, NY AHEC, NY ACP, NY AAFP)

| Regarding goals and principles | Cited learnings, lessons, findings | Policy / payment considerations |
|---|---|---|
| <p><u>What American consumers want</u> from medical providers (AAFP, Green, Graham et al. 2004) found that patients lack clarity about who primary care physicians are and what their roles should be. Consumers want</p> <ul style="list-style-type: none"> • PC provider in insurance plan and • Conveniently located. • An appointment quickly at their convenience. • Good communication • Value relationship above all else but • Appreciate the importance of technology and information management. • Coordination of their overall care but understand that no one person can be skilled in all areas of medicine. • Quality care but generally assume it is provided <p><u>Goals of medical home:</u> A point of access to health care organized around the patient’s needs and built on a relationship between a patient and a physician.</p> <ul style="list-style-type: none"> • A primary healthcare base providing 90% of health needs and coordinating specialty referrals, ancillary services. • A source of first contact care and comprehensive care across a continuum of preventive, acute and chronic health care needs. • A place where they get to know you. (Grumbach & Bodenheimer 2002) <p>Medical home most often a PC office, but specialty offices may choose to organize themselves to provide or coordinate spectrum of comprehensive services.</p> <p><u>A rationale and literature review</u> is provided for each of the Medical Home joint principles:</p> <ol style="list-style-type: none"> 1. Personal physician 2. Physician-directed medical practice 3. Whole person orientation 4. Care coordinated/integrated across all domains of care system 5. Quality & safety 6. Info technology 7. Enhanced access <p><u>Medical home foundations:</u> Patients & families have continuity care founded on a long-term relationship with a provider and a provider team. Health care from perspective of the pt & family.</p> <p>(continued on next page)</p> | <p><u>Financial experience:</u> Community Health Centers (CHCs) are largest network of medical homes in US. Average cost caring for a patient in a CHC was \$2,569 compared with \$4,379 for the general population, a 41% savings. Special needs populations experience an even greater savings.(National Association of Community Health Centers 2005)</p> <p>Source of funds for supporting the medical home will come from the anticipated 30% savings realized by assuring every patient has access to a personal care physician practicing in a medical home model practice</p> <ul style="list-style-type: none"> • Areas with higher ratios of PC physicians have lower total health care costs.(Mark, Gottlieb et al. 1996; Franks and Fiscella 1998) • A case of community acquired pneumonia is more expensive if cared for by specialists with no difference in outcomes.(Whittle, Lin et al. 1998) • A 20% increase in the supply of generalists in the United Kingdom is associated with 14/100,000 population fewer admissions for acute illnesses and 11/100,000 fewer for chronic diseases decrease.(Gulliford 2002) • The rates of hospitalizations for heart disease and diabetic patients (case mix controlled) were 90% higher for cardiologists and 50% higher for endocrinologists over family physicians.(Greenfield, Nelson et al. 1992; Basu and Clancy 2001) • Populations served by Community Health Centers show lower rates of costly health conditions and 5.8 fewer preventable hospitalizations per 1000 persons. (Epstein 2001; Starfield and Shi 2004) <p><u>Quality saves money.</u></p> <ul style="list-style-type: none"> • Maintaining HbA1c at 7 in diabetic patient saves \$279 a year in health costs per patient. • Keeping a diabetic’s LDL below 100 saves \$369 per year and keeping the blood pressure below 130/80 saves \$494 according to data collected from patients cared for in the Bridges to Excellence program. • Keeping all measures at target saves \$1,059 per patient per year. • Preventing one MI saves \$36,256 and avoiding one dialysis patient by controlling diabetes can save \$44,206.(Excellence 2005) <p><u>Demonstration projects cited:</u></p> <ul style="list-style-type: none"> • UnitedHealth Group (FL) PC helping PC practices in 2007 to incorporate QI and care mgmt systems to increase access & quality. • CIGNA, Humana, Wellpoint and Aetna express interest in using reimbursement strategies to support medical homes (Backer 2007) • Boeing “Ambulatory Intensive Care Unit” to improve affordability, quality, pt. experience (Helle & Fernandopulle 2007), focusing on team health care and linkage of specialists. Costs of project 9.9%, to date focused on 700 high utilizing patients, has saved 46.8% over historic costs. At heart is dedicated physician & nurse with 24/7 access via email, phone, home visits. | <p><u>About FFS payment model</u></p> <ul style="list-style-type: none"> • Little data exists comparing reimbursement methodologies for medical homes. But pure FFS methodology is barrier to achieving goals for health care.(Medicine 2006) Reimbursement strategies must create active care coordination center between the medical home and the patient that ultimately reduces the number of physicians billing for patient care.(Pham, Schrag et al. 2007) • AMA, AAFP, National Business Group on Health convinced that present FFS payment is a problem. FFS rewards procedures, a component with the greatest potential for overuse, and undervalues primary care services. (Berenson 2007; Orszag and Ellis 2007) • Consumer Reports (2007) lists 10 procedures (back surgery, heartburn surgery, prostate tx, implanted defibrillators, coronary stents, C-sections, whole body screens, angiography, high-tech mammography, virtual colonoscopy) for which overuse is driven by existing payment methodologies • AMA sponsors the resource-based relative value scale update committee (RUC 2007) which is primary advisor to CMS for RVU decisions. RUC has 30 members with 23 appointed by national medical specialty societies. Meetings closed to outside observation except by invitation and proceedings not publicly available for review. To date, more than 90% of RUC rec. enacted by CMS. In 2006, based on RUC recommendations, CMS increased RVUs for 227 services and decreased them for 26.(Goodson 2007) • Private insurers mirror Medicare therefore they also pay higher per time unit fees for procedures. (Bodenheimer, Berenson et al. 2007) • Payment must recognize added value to patients by physician and non-physician staff who make the patient-centered medical home work, including activities outside face-to-face visit., e.g., care coordination as well as emotional and psychological support and management. Payment strategies need to support health info technology, e-mail, phone consultation and adjusted by case mix. (Landon, Schneider et al. 2007) • Practices with attributes of medical home will be PC practices, but endocrinologists caring for diabetic patients or nephrologists caring for patients on dialysis may incorporate medical home attributes to become eligible for medical home reimbursements and achieve similar outcomes.(McDonald, Harrison et al. 2007) <p><u>About assistance, care management fees and rewards for change:</u></p> <ul style="list-style-type: none"> • Large and small practices will benefit from a statewide program as modeled by the AAFP, AAP and ACP, though large practices may have greater internal expertise to adopt medical home principles. Practices, including Community Health Centers, are business entities for which rewards for change must exceed the cost of change. Conversion to medical home model costs \$50,000 for every 3 physicians. Single disease programs offer attractive simplicity but require investment similar to global programs that have the potential to impact all patients, regardless of dx. Global programs are also less likely to lead to discrimination against patients who are unable to achieve benchmarks (de Brantes 2007). • Several models have used a per-member-per-month mgmt fee ranging from \$5.50 per month for all Medicaid patients with or without chronic disease in North Carolina (Carolina 2007) to \$10.00 PMPM for patients with mental health diagnosis complicated by a medical condition.(Rosenthal, Horwitz et al. 1996) Other models paid fractional fees for specific activities, including maintenance of chronic disease registries, testing records, guidelines implementation, outcomes tracking and hospitalization rates. Bridges to Excellence project demonstrated that well persons with a medical home realizes cost savings of \$110 per patient per year.(Excellence 2005) Therefore capitation of \$5.50 per-member-per-month, yielding \$66 per year to the practice comes close to splitting the savings between provider and payer. • At \$5.50 PMPM for a typical primary care panel of 1800 patients per provider generates \$99,000 per year, which would offset physician time, lower FFS income and enough to hire RN case manager and an assistant to manage the care coordination system and reporting an collaborative relationships. <p><u>About Pay for Performance</u></p> <ul style="list-style-type: none"> • Beyond the management fee, a quality pay-for-performance (P4P) incentive should also be offered that recognizes achievement of standards of care. The most accurate source of data is patient record (Pawlson, Scholle et al. 2007). Rewards must be enough to trigger continuous efforts at improvement but infrequent enough to reflect actual change. Standards must be adjusted for patient population but should aspire to national standards of care. • AMA Physician Consortium for Performance Improvement and the National Quality Forum endorsed a list of quality measures eligible for incentives. (http://www.ama-assn.org/ama/pub/category/4837.html) Programs that started with a limited number of incentives and grown as skill at collection and validation of data improved the most successful. • Patients in health plans that include a pay-for-performance incentive do receive higher quality care that persists and improves over 6 years.(Gilmore, Zhao et al. 2007) • Payments must be enough to encourage change.(Casalino, Devers et al. 2003)and be made public; reporting improves patient trust.(Health 2007) • Criteria should be measurable, based on evidence and amenable to medical case management.(Dunbar, Hiza et al. 2004) |

NY medical home evidence statement (cont'd)

Builds off a case mgmt model by The Group Health Coop Chronic Care Model (Von Korff, Gruman et al. 1997) Responsibility for care and care coordination resides with pt's personal physician in association w healthcare team.

- The pt and physician decide the specific health care objectives and then choose the best way to achieve these objectives. (Barr 2006)
- The team may form and reform according to pt needs and includes nurses, social workers, care mgrs, dietitians, pharmacists, physical and occupational therapists as well as family and community.

Supports integration of medical and behavioral services in general medical office (Finch 2005). Integrated bio-psycho-social view of medical home consistent with pt beliefs and documented to enhance wellness and reduce costs. (Engel 1977; Rosenthal and Campbell-Heider 2001; Bodenheimer, Lorig et al. 2002)

Medical Home, and patient-centered care is internationally recognized strategy to cost effectively incorporate quality and value into health universal health care (Mahar 2006).

- North Carolina's Medicaid program, Community Care of North Carolina has physician-led networks that rely on medical home model to save costs & improve quality. For capitation of \$5.50 / mo per Medicaid pt, practices use evidence based guidelines for at least 3 conditions, track tests & referrals, measure and report on clinical & service performance. Program spent \$8.1 million between 7/02 and 7/03, saving more than \$60 million over historic costs. In the second year \$10.2 million spent but \$124 million saved. 2005 savings grew to \$231million. (Arvantes 2007)
- Erie County NY Partial Capitation Managed Program in 1990 for Medicaid/Medicare pts with chronic disabilities including substance abuse, with a capitated PC home for each enrollee. Patient access to special MH services continued at usual Medicaid FFS. Improved quality at savings of \$1 million / yr for every 1000 enrollees (Rosenthal, Horwitz et al. 1996). Less duplication of diagnostic testing and fewer ER visits, hospitalizations
- Buffalo Medical Group NY, a 100 physician multi-specialty group made medical home for all its diabetic patients (n=2151) and assigning a nurse case manager for every 800 patients to score the quality of mgmt of every three months and schedule lab tests, eye and PC appointments. Now achieves target HbA1c (<7) on 57% of patients, exceeding NCQA standards. Cost is \$11.90 per pt / mo, partly reimbursed thru negotiated contracts with insurance carriers. (Notaro '07)
- Veterans Affairs Administration integrated information technology based on PC and saw improved quality at significant savings, costing \$6,000 less per year to care for veteran over 65 than for a Medicare recipient.(Moran 2005)

About mixed payment models:

- After quality and outcomes reporting initiated in UK in 2000, quality improved. When financial incentives added in 2004, quality improvement steepened as practices employed more provider staff, installed EHRs, increased networking with community agencies. Nurses given greater team responsibility and reported greater job satisfaction.(Campbell, Reeves et al. 2007; McDonald, Harrison et al. 2007)
- Reimbursement for medical homes should incorporate a FFS component, a per-patient care-management stipend and a pay-for-quality award. The present fee-for-service payments fails to compensate primary care physicians for 40% of the work of PC.(Gottschalk and Flocke 2005) The Medicare RBRVS based fee schedule has never compensated coordinating care and patient education and has undervalued the office visit. Recent 2007 changes increased primary care reimbursement only 5%, not the 37% projected by Medicare. (Ginsburg and Berenson 2007)
- Reform should begin by establishing a blended fee schedule consisting of a FFS (per visit) fee plus a monthly management fee for practices serving as medical homes and an additional bonus for meeting and reporting quality performance goals.(Davis 2007).
- Besides the office visit face-to-face FFS charges, virtual office visits, using email or Web-based portal use, should also be reimbursed. Kaiser Permanente of Colorado is reimbursing 95% of the 99213 office visit fee per virtual office visit (CPT code 0074T ~ \$50 in 2007) (Eads 2007)

About medical home oversight and training

- Oversight will be essential to success of a statewide medical home model. England and Wales instituted the National Institute for Health and Clinical Excellence (NICE) to manage incentives and define objectives of the health care system and publish clinical appraisals on diagnostic and treatment efficacy developed by a team of full time investigators, health professionals working in the National Health Service, patients, employers and government.(Excellence 2005). NICE is challenged to balance national agendas versus individual benefit and to avoid over emphasis on cost containment. (www.nice.org.uk) A functional oversight group informs, advises and protects providers through the development of evidence based guidelines and would be important to a statewide health system.
- Needs to be reform in physician training. PC residents need theory and experience in the management of a population of patients, patient-centered care, personal medical home, best knowledge at the point of care, continuous access to multimodal communication, a new platform of care, time intensive visits, group visits, teamwork and interpersonal skills, and financial practice management. (Scherger 2007)

American Cancer Society Medical Home Model Review (3/07). The Medical Home Model — A Path to Lower Costs and Better Health Outcomes? Written to “view PCMH through the cancer lens”

| Regarding Goals / ends / measures | Governing principles Distilled from review | Regarding components / functions | Regarding financial support/payment models | Regarding leadership / change methods | Cited learnings, lessons, findings | Further research questions |
|--|---|---|---|--|---|---|
| <p>Improve outcomes, experience and lower costs by</p> <ul style="list-style-type: none"> • Providing an environment in which patients can make better informed decisions about their treatment • Providing a platform for comprehensive coordinated care that is safe, affordable, and high quality | <p>1) The six aims and new rules of the 2001 IOM Crossing Quality Chasm report</p> <p>2) Properties of medical home</p> <ul style="list-style-type: none"> • Pt has a usual source of healthcare • Shared decision-making responsibility with patient and provider • Personalized care coordination • Access beyond acute care episode • Identification of key medical and community resources • Address care for all stages of life: acute, chronic, preventive, end-of-life • Coordinates information to others involved in care | <p>Medical Home concept is moving along a continuum with previous models of care coordination and delivery</p> <ul style="list-style-type: none"> • From disease-focused to patient-focused • From patient navigator model to disease-mgmt or gatekeeper model to advanced medical home / patient-centered medical home | <p>Present system has no incentives for coordination and coordination. It encourages volume while discouraging coordination and communication.</p> <p>Need better electronic info technology but startup cost is great and most of the savings goes to insurers through fewer redundant tests and procedures</p> <p>Accountability and risk for medical homes not well specified.</p> <ul style="list-style-type: none"> • Providers are not at risk • But other levels of responsibility unclear. Is it advisory? Or managerial responsibility such as actual coordination of services beyond what medical home does directly? | <p>Few practices now have the characteristics associated with primary care medical home. They will need</p> <ul style="list-style-type: none"> • Major structural / org. changes • Financial incentives • Health info technology • A built-up PC workforce • Patient incentives to use PCMH, e.g., reducing barriers such as cost, copay patterns for contacts and prevention, ability to contact by phone or after hours | <p>Having a regular source and continuous care with the same physician over time leads to better quality, outcomes and costs.</p> <p>But evidence of cost savings for PCMH model is mixed.</p> <ul style="list-style-type: none"> • A CBO analysis concluded that these approaches may improve quality but do not substantially reduce costs, and there is significant investment to the practice and provider. • If everyone had a medical home, costs would decrease 5.6% with improved quality. (Spann SJ, for the members of Task Force 6 and The Executive Editorial T: Report on Financing the New Model of Family Medicine. Ann Fam Med 2004; 2(suppl_3):S1-21) • Savings would be achieved by changing reimbursement to PC practices to support enhanced pc services with Medicare beneficiaries. Mandatory enrollment could result in net savings of 10 billion over 10 years. (C. Schoen, S. Guterman, A. Shih, J. Lau, S. Kasimow, A. Gauthier, and K. Davis, Bending the Curve: Options for Achieving Savings and Improving Value in U.S. Health Spending, The Commonwealth Fund, Dec 2007). | <ul style="list-style-type: none"> • Is broader health care reform necessary before implementing the medical home model? • As interest in medical homes has grown, so have definitions of what it means to provide one. What is a single definition that all stakeholders can operationalize? • Would the definition of medical home be universal among Medicaid, Medicare, and private insurers? Multi-payer trials needed because a practice cannot invest in a medical home for only a portion of their patients • What would the PCMH model look like for cancer or other diagnosis patients? • Research focused on children in medical homes, but research is needed to see how the medical home works for adults and whether other trained providers could be effective for providing preventive care. • Costs to implement the medical home in a physician's practice? When will both provider and payer see savings? • Are other models of delivery effective? What are the impacts of retail clinics (Walmart, Walgreens, CVS, Target) and employer-based providers? • Besides primary care physicians, who else will be able to deliver the components of the PCMH model? • Should the government provide incentives for physicians to practice in rural and poor urban areas? |

Institute for Clinical Systems Improvement
Health Care Home State of the Art: National Literature framework. 12/30/08

NCQA Standards and Guidelines for Patient-Centered Medical Home—Physician Practice Connections PC-PCMH CMS Version, 10/08

| Goals / ends | Governing principles | Medical Home standards and criteria areas | Scoring method | History, outside comment |
|--|--|---|--|--|
| <p><u>Purpose of the program:</u> To assess how medical practices are functioning as patient-centered medical homes.</p> <p><u>Vision:</u> The Patient Centered Medical Home is a health care setting that facilitates partnerships between individual patients, and their personal physicians, and when appropriate, the patient's family.</p> <p>Care is facilitated by registries, information technology, health information exchange and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner.</p> <p><u>Larger goals:</u> Address the crisis in primary care, e.g., PC physician shortage and disillusionment, avoidable costs, and need for coordinated care & longitudinal healing relationships.</p> <p><u>Strategy:</u> Recognize physician practices that use systematic, patient-centered, coordinated care mgmt. processes.</p> <p><u>Measures:</u> Specific measurable elements for each standard in column 3</p> | <p>Builds on the joint principles for medical home issued by AAFP, ACP, AAP, AOA:</p> <ol style="list-style-type: none"> 1. A relationships with a personal physician 2. Physician-directed medical practice 3. Whole-person orientation 4. Care is coordinated or integrated 5. Quality and safety built in 6. Enhanced access beyond customary visit methods 7. Payment recognizing added value from medical home | <p>Standard 1. <u>Pt. Access & Communication</u></p> <ol style="list-style-type: none"> A. Access and communication processes (12elements) B. Access and Communication Results (5 elements) C. Giving patient information on role of medical home (9 elements) <p>Standard 2. <u>Patient tracking & registry functions</u></p> <ol style="list-style-type: none"> A. Basic system for managing patient data (18 elements) B. Electronic system for clinical data (10 elements) D. Organizing clinical data (5 elements) E. Identifying important conditions (3 elements) F. Use of system for population management (7 elements) G. Comprehensive health assessment (6 elements) <p>Standard 3. <u>Care management</u></p> <ol style="list-style-type: none"> A. Guidelines for important conditions (3 elements) B. Preventive service clinician reminders (4 elements) C. Practice organization (5 elements) D. Care management for important conditions (13 elements) E. Continuity of Care (11 elements) <p>Standard 4. <u>Patient self-mgmt support</u></p> <ol style="list-style-type: none"> A. Documenting communication needs (2 elements) B. Self-management support (7 elements) <p>Standard 5. <u>Electronic prescribing</u></p> <ol style="list-style-type: none"> A. Electronic prescription writing (2 elements) B. Prescribing decision support--safety (15 elements) C. Prescribing decision support--efficiency (2 elements) <p>Standard 6. <u>Test tracking</u></p> <ol style="list-style-type: none"> A. Test tracking and follow-up (6 elements) <p>Standard 7. <u>Referral tracking</u></p> <ol style="list-style-type: none"> A. Referral tracking and coordination (4 elements) <p>Standard 8. <u>Performance reporting</u></p> <ol style="list-style-type: none"> A. Measures of performance (4 elements) B. Patient experience data (4 elements) C. Reporting to physicians (2 elements) D. Setting goals and taking action (2 elements) <p>Standard 9. <u>Advanced e-communication</u></p> <ol style="list-style-type: none"> A. Availability of interactive web site (6 elements) | <p>There are 9 standards, including 10 "must pass" elements, which can result in one of three levels of recognition.</p> <ul style="list-style-type: none"> • There is at least one item or element for each standard. An element describes a specific component of performance that is individually evaluated and scored. • An overall score is created for each standard from 0% to 100%. For CMS demonstration purposes, practices must achieve a 50% or higher score on required elements. <p>A web-based scoring tool is available, and the standards are available at no cost.</p> | <p><u>History:</u> The effort began in context of children with special needs but now generalized to entire population. This is the second and current version (10/08) of these standards.</p> <p><u>Outside comment:</u> Some believe the definition of Patient-Centered Medical Home as defined by the Joint Principles, and as further defined by the NCQA PPC-PCMH standards, needs further work. For example, some believe these do not adequately address:</p> <ul style="list-style-type: none"> • Behavioral and psychosocial issues • Care coordination / case management, • Reorientation of the primary care practice as a multidisciplinary team • Need for practices to document improved processes and outcomes to indicate level of model implementation • Shared decision-making • The role of nurse-led primary care practices. <p>Others worry that the PCMH is becoming too inclusive and needs to be better focused on the practice changes that will make the biggest impact on outcomes and cost.</p> <p>(PCPCC Purchaser's guide, 2008). www.pcpcc.net. Patient Centered Primary Care Collaborative</p> |

AAFP / TransforMED Medical Home model and demonstration (extracted from website. version 9/08, www.transformed.com)

| Goals / ends | Governing principles | Components of TransforMed Patient-Centered Medical Home | | Stage and results |
|---|---|--|--|---|
| <p>Goal of medical home: "Everyone should have a personal medical home that serves as the focal point through which all individuals—regardless of regardless of age, sex, race or socioeconomic status—receive acute, chronic and preventive medical services.</p> <p>Through ongoing relationship with a family physician in their medical home, patients can be assured of care that is not only accessible but also accountable, comprehensive, integrated, patient-centered, safe, scientifically valid, and satisfying to both patients and their physicians." (2006)</p> <p><u>Goal of the demonstration project:</u> To assess the usefulness and impact on quality of care and business performance of the Future of Family Medicine Report's new model.</p> <p><u>Principle:</u> Primary care treats the whole person and TransforMED Medical Home Model sees that all elements of Medical Home practice are interrelated and "treats the whole practice."</p> <p><u>Strategy:</u> Demonstration projects to test the model of care to evaluate if it truly is workable in a variety of everyday family medicine settings.</p> <p><u>Measures</u> Patient outcomes include quality of:</p> <ul style="list-style-type: none"> • Chronic disease management, • Preventive service delivery • Acute illness care • Mental health care • Patient satisfaction • Patient-centeredness of care. <p>Practice outcomes include:</p> <ul style="list-style-type: none"> • Clinician and staff quality of life • Practice processes • Financial viability. <p>Case study approach to elucidate the process of practice change and identify factors that affect transformation.</p> <p>Nationally recognized metrics, including from Ambulatory Quality Alliance, Nursing Care Quality Initiative, Institute for Healthcare Improvement, Medical Group Management Association, American Medical Association</p> | <p>Based in joint principles of medical home of AAFP, ACP, AAP, and AOA</p> <p>Model: A continuous relationship with a personal physician coordinating care for both wellness and illness</p> <ol style="list-style-type: none"> 1. A personal medical home 2. Patient-centered care that is both responsive and prospective 3. Multidisciplinary team as source of care 4. Elimination of scheduling and communication barriers to care—open access including email, web and voicemail communication 5. Advanced data-based information systems, including electronic health records 6. Redesigned, more functional offices and work processes 7. Integrated care that has a whole-person orientation 8. Care provided within a community context—culturally sensitive and community-oriented 9. Emphasis on quality and safety and evidence—using systems 10. Enhanced practice finance* and sustainable practice, margins through efficiencies and new revenue streams 11. Commitment to provide family medicine's consistent set or "basket" of services—directly or through established relationships <p>*Also features developing alternative reimbursement models</p> <p>Vision also strongly features the role of clinic-based leadership, including:</p> <ul style="list-style-type: none"> • Locally shared vision • Visible leadership • Team development • Change acceleration • Project management—the technical side of change • Fostering a culture of improvement • Enjoy the journey-celebrate along the way <p>(Bruce Bagley AAFP/STFM Practice Improvement plenary, 12/07)</p> | <p><u>Access to Care & Information</u></p> <ul style="list-style-type: none"> • Same-day appointments • After-hours access coverage • Lab results highly accessible • Online patient services • e-Visits • Group visits • Culturally sensitive care <p><u>Practice Services</u></p> <ul style="list-style-type: none"> • Comprehensive care for both acute & chronic conditions • Prevention screening and services • Surgical procedures • Ancillary therapeutic and support services • Ancillary diagnostic services <p><u>Care Management</u></p> <ul style="list-style-type: none"> • Population management • Wellness promotion • Disease prevention • Chronic disease management • Care coordination • Patient engagement and education • Leverages automated technologies <p><u>Continuity of Care Services</u></p> <ul style="list-style-type: none"> • Community-based services • Collaborative relationships <ul style="list-style-type: none"> • Hospital care • Behavioral health care • Maternity care • Specialist care • Pharmacy • Physical therapy • Case management | <p><u>Practice Management</u></p> <ul style="list-style-type: none"> • Disciplined financial management • Cost-Benefit decision-making • Revenue enhancement • Cost-Benefit decision-making • Optimized coding & billing • Personnel/HR management • Facilities management • Optimized office design/redesign • Change management <p><u>Health Information Technology</u></p> <ul style="list-style-type: none"> • Electronic medical record • Electronic orders and reporting • Electronic prescribing • Evidence-based decision support • Population management registry • Practice Web site • Patient portal <p><u>Quality and Safety</u></p> <ul style="list-style-type: none"> • Evidence-based best practices • Medication management • Patient satisfaction feedback • Clinical outcomes analysis • Quality improvement • Risk management • Regulatory compliance <p><u>Practice-Based Team Care</u></p> <ul style="list-style-type: none"> • Provider leadership • Shared mission and vision • Effective communication • Task designation by skill set • Nurse Practitioner / Physician Assistant • Patient participation • Family involvement options | <p>36 practices began 6/06; private and group practices</p> <ul style="list-style-type: none"> • 18 facilitated practices • 18 self-directed practices <p>Center for Research in Family medicine and PC (CRFMPC) oversees evaluation. No evaluation evidence public at this point. Demonstration concluding in 2008 to be published in 2009</p> <p>"Learning Labs" is public online resource for updates and insights emerging from the national demonstration project. www.transformed.com/learningLabs.cfm</p> <p>TransforMED's Medical Home IQ (MHIQ) is a web-based self-assessment tool for primary care practices seeking to become Medical Homes. TransforMED now lets users convert their Medical Home IQ score into an estimate of how they might score on the NCQA PPC-PCMH</p> |

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CMS Medical Home Demonstration design and qualifying criteria (Draft October 3, 2008): Mathematic Policy Research Inc. P.O. Box 2393 Princeton, NJ 08543-2393. (609) 799-3535

| Purpose, principles, goals | Eligibility and participation in demonstration | CMS Medical Home qualifying criteria. For Tier 2, all of the first 19 plus three of 20-28. For Tier one, only 17 of these (not listed separately here) |
|---|--|--|
| <p><u>Purpose of this Report:</u> Present the design of CMS) Medical Home Demonstration</p> <p><u>Purpose of the Demonstration:</u></p> <ul style="list-style-type: none"> Determine whether Medicare medical homes reduce costs to Medicare by avoiding unnecessary care, coordinating and rationalizing care, and avoiding preventable hospitalizations and readmissions. Determine whether medical homes improve the quality of health care by avoiding inconsistent treatments and medications, increasing the amount of preventive care, and improving patient adherence. <p><u>Goals of medical home</u> The medical home model (using joint principles AAFP, ACP, AAP, AOA; 2007) is expected to achieve these goals largely through integration and coordination of health care by primary care physicians. Integrated health care is expected to enhance patient adherence to recommended treatment and avoid</p> <ol style="list-style-type: none"> Hospitalizations, unnecessary office visits, tests, and procedures; Use of expensive technology or biologicals when less expensive tests or treatments are equally effective; and Patient safety risks inherent in inconsistent treatment decisions. <p><u>Observations about Medicare applications</u></p> <ul style="list-style-type: none"> Eighty-six percent of beneficiaries of fee-for-service (FFS) Medicare have one or more chronic conditions (Peikes et al. 2008), and many of these individuals suffer from five or more chronic conditions (Anderson 2005). Most FFS Medicare beneficiaries with chronic conditions receive care from several physicians—often 10 or more in a given year The fragmentation of care for Medicare beneficiaries (MedPAC 2006; Pham et al. 2007; Starfield et al. 1976) and its relationship to rapidly rising health care costs (Parchman et al. 2005; Kripalani et al. 2007) are well documented. | <p>Which practices eligible:</p> <ul style="list-style-type: none"> Practice must have the capability of providing medical home services for at least the lower tier level. Participating physicians in the practices to be board certified Participating physicians provide first contact and continuous care for individuals under his or her care. General medicine, general practice, family practice, and geriatricians are eligible. Radiology, pathology, anesthesiology, dermatology, ophthalmology, emergency room practices, chiropractors, psychiatry, and surgery are not eligible specialties. Other specialties and subspecialties may be eligible. <p>Which beneficiaries eligible:</p> <ul style="list-style-type: none"> Has one or more eligible diagnoses—a person having a chronic condition if a panel of five internists agreed that the condition had lasted or was expected to last twelve or more months and resulted in functional limitations and/or the need for ongoing medical care. Two or more ambulatory claims, or one inpatient claim for one or more of these diagnoses or conditions within the previous year. Medicare is the beneficiary's primary health insurer and participates in both Parts A and B of Medicare Is not in any of the excluded groups <ul style="list-style-type: none"> Enrolled in a Medicare Advantage plan. Receiving Medicare Hospice benefits. Resides in a long-term custodial nursing home. Receives end stage renal disease (ESRD) benefits. Participates in another Medicare demonstration. <p>How participating practices are reimbursed:</p> <ul style="list-style-type: none"> Reimbursement is PMPM, adjusted by disease burden, indicated by hierarchical condition categories (HCC) score that recognizes cost of providing medical home services increases with greater disease burden of patients. Nationwide, 25 percent of beneficiaries have an HCC score greater than or equal to 1.6, and are expected to have Medicare costs that are at least 60 percent higher than average. Tier 1: \$40.40 to \$80.25 PMPM Tier 2: \$51.70-\$100.35 PMPM If the demonstration generates more than 2% savings, CMS will share a large portion with participating providers <p>How demonstration sites selected: Demonstrations to operate in up to 8 states that include urban, rural and medically underserved.</p> | <p><u>Continuity</u></p> <ol style="list-style-type: none"> The practice discusses with patients and presents written information on the role of the medical home that addresses up to 8 areas. Establishes written standards on scheduling each patient with a personal clinician for continuity of care and the practice collects data to show that it meets its standards on continuity. <p><u>Clinical Information Systems</u></p> <ol style="list-style-type: none"> The practice uses an electronic data system that includes searchable data such as patient demographics, visit dates and diagnoses (up to 12 specific factors), and uses an electronic or paper-based system to identify clinically important conditions or risk factors among its population, and has an electronic health record, certified by the Certification Commission on Health Information Technology (C-CHIT), that captures searchable data on clinical info such as blood pressure, lab results or status of preventive services (up to 9 areas). <p><u>Delivery System Redesign</u></p> <ol style="list-style-type: none"> The practice establishes written standards to support patient access, including policies for scheduling visits and responding to telephone calls and electronic communication (up to 9 factors). The practice collects data to demonstrate that it meets standards related to appointment scheduling and response times for telephone and electronic communication (up to 5 specific factors). Defines roles for physician and non-physician staff and trains staff, with non-physician staff, involved in reminding patients of appointments, executing standing orders and educating patients/families. Uses electronic or paper-based tools including med lists and other tools such as problem lists, or structured templates for notes or preventive services to organize and document clinical info in record Conducts a comprehensive health assessment for all new pts to understand their risks and needs including past medical hx, risk factors and preferences for advance care planning (up to 5 factors). For three clinically important conditions, the physician and non-physician staff conduct care mgmt using an integrated care plan to set goals, assess progress and address barriers (5 factors). For three clinically important conditions, the physician and non-physician staff conduct care management planning ahead of the visit to make sure that information is available and the staff is prepared as well as following up after the visit to make sure that the treatment plan (including medications, tests, referrals) is implemented. The practice identifies appropriate evidence-based guidelines that are used as the basis of care for clinically important conditions. <p><u>Patient/Family Engagement</u></p> <ol style="list-style-type: none"> The practice supports patient/family self-management through activities such as systematically assessing patient/family-specific communication barriers and preferences, providing self-monitoring tools or personal health record, and providing a written care plan. The practice supports patient/family self-management through providing educational resources, and providing/connecting families to self-management resources. The practice encourages family involvement in all aspects of patient self-management. <p><u>Coordination</u></p> <ol style="list-style-type: none"> The practice systematically tracks tests and follows up using steps such as making sure that results are available to the clinician, flagging abnormal test results, and following up with patients/families on all abnormal test results (up to 4 specific factors). The practice coordinates referrals designated as critical through steps such as providing the patient and referring physician with the reason for the consultation and pertinent clinical findings, tracking the status of the referral, obtaining a report back from the practitioner, and asking patients about self-referrals and obtaining reports from the practitioner(s). The practice reviews all medications a patient is taking including prescriptions, over the counter medications and herbal therapies/supplements. The practice on its own or in conjunction with an external organization has a systematic approach for identifying and coordinating care for patients who receive care in inpatient or outpatient facilities or patients who are transitioning to other care (up to 6 specific factors). The practice reviews post-hospitalization medication lists and reconciles with other medications. <p><i>And 3 of these additional 9 capabilities</i></p> <p><u>Clinical Information Systems</u></p> <ol style="list-style-type: none"> The practice uses an electronic system to write prescriptions which can print or send prescriptions electronically, clinicians in the practice write prescriptions using electronic prescription reference information at the point of care, which includes safety alerts that may be generic or specific to the patient (up to 8 specific factors), and clinicians engage in cost-efficient prescribing by using a prescription writer that has general automatic alerts for generic or is connected to a payer-specific formulary. The practice provides patients/families with access to an interactive Web site that allows electronic communication. The practice provides for patient access to personal health information such as test results or prescription refills or to see elements of their medical record and import elements of their medical record into a personal health record. <p><u>Delivery System Redesign</u></p> <ol style="list-style-type: none"> Measures or receives data on performance such as clinical process, clinical outcomes, service data or pt safety issues, and collects data on patient experience with care, addressing up to 3 areas. The practice reports performance data to physicians. The practice uses performance data to set goals and take action where identified to improve performance. The practice uses electronic information to generate lists of patients and take action to remind patients or clinicians proactively of services needed, such as patients needing clinician review or action or reminders for preventive care, specific tests or follow-up visits (up to 5 specific factors). Uses a paper-based or electronic system for reminders at the point of care based on guidelines for preventive services such as screening tests, immunizations, risk assessments and counseling. The practice uses a paper-based or electronic system for reminders at the point of care based on guidelines for chronic care needs. |

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Patient Centered Primary Care Collaborative: Demonstration Projects (from Patient-Centered Medical Home—Building Evidence and Momentum: A compilation of PCMH pilot and demonstration projects; Also at www.pcpcc.net)

PCPCC is a coalition of large employers, PC societies, national health plans, patients' groups. Purpose is to support Patient Centered Medical Home as a comprehensive solution to problems in quality, clinical outcomes, patient satisfaction and cost / affordability, Based in the Joint Principles, these multi-stakeholder pilots offer a point of entry PC team that provides continuous, coordinated care, helping patients navigate the segmented medical system. By engaging patients with their doctors, they can take real accountability for their health—savvy consumers and care and better health outcomes

| Project name, location | Project status | Sponsors / conveners | Purpose / focus / questions | Expected / actual practices / populations | Medical Home recognition | Methods / transformation support | Payment model | Evaluation / Results |
|--|--|---|---|--|---|--|---|--|
| United Health Group PCMH Demonstration Program Arizona—Phoenix / Tucson Metros | Taking provider applications to start 1/09 for 36 mo | United Healthcare | To demonstrate the value of a PCMH practice. The "home" physician responsible for the PC of the individual patient and managing / arranging care collaboratively with UHG. Emphasis on primary disease prevention and improving quality for chronically ill; outreach to members to be more engaged in their overall health and wellness. UHG committed to work cooperatively with medical groups to further these goals. | <ul style="list-style-type: none"> • 3-6 practices; 20 physicians • Internal medicine, family medicine • Commercial, Medicare Advantage business lines • 6000 covered lives • Medicaid and two ASO's under consideration | NCQA PPC-PCMH UH Group also promotes the "Premium Designation Program" | Industry recognized consultative vendor to assist with transformation planning, coaching facilitation | <ul style="list-style-type: none"> • Monthly care mgmt fee • Performance bonus | United Healthcare internal measurement plan with vendors for assessing progress and review of overall measurement approach <ul style="list-style-type: none"> • Clinical Quality • Cost • Patient experience / satisfaction • Provider experience / satisfaction |
| Colorado Multi-Stakeholder Multi-State PCMH Pilot Colorado—Front Range- CO Springs, Denver Metro, Fort Collins. Partner State Ohio | Technical assistance for practices to achieve at minimum NCQA PPC-PCMH level 1 by 11/08. Start by 4/1/09 for 2 years | <u>Convenor:</u> CO Clinical Guidelines Collaborative. <u>Stakeholders:</u> Aetna; Anthem-Wellpoint; CIGNA; Humana; Rocky Mtn Health Plan; UnitedHC; CO Medicaid; CO CBGH; IBM; PCPCC; AAFP; ACP; CO Med Soc | To design & implement a Multi-Stakeholder Multi-State PCMH Pilot consistent with Joint Principles of PCMH. CO partnering with Health Improvement Collaborative of Greater Cincinnati in Ohio. The pilot requires significant investment but will create significant returns. <ul style="list-style-type: none"> • Generate knowledge on how to better sustain PC • Transform current system of health care, and create a more cost-effective health care system. • Examine take up of the medical home intervention and identify factors associated with fulfillment of the structural criteria defined by the PPC-PCMH • Examine cost, utilization, quality, satisfaction | <ul style="list-style-type: none"> • 10-15 practices • Number of physicians dependent on number of practices chosen • 2-5 physicians per practice • Internal medicine, family medicine • Commercial, Medicare Advantage, Medicaid Managed Care business lines • 30,000 covered lives | NCQA PPC-PCMH | CO Clinical Guidelines Collaborative to provide technical assistance to support pilot practices to achieve NCQA PPC-PCMH. QIC (Quality Improvement Coach) provide practice level support to implement consistent & reliable processes. <ul style="list-style-type: none"> • Chronic (Planned) Care Model • Lean training principles & improv model • Learning Collaborative Sessions supplement In-Office coaching. This model consistent with the framework of National Improving Performance in Practice (IPIP) Program. | <ul style="list-style-type: none"> • 3-Tiered reimbursement method consistent with Joint Principles of PCMH. • FFS • Care mgmt fee that increases with higher levels of NCQA PPC-PCMH achievement. Payment begins at Level 1 | Matched Comparison Group methodology used to evaluate effectiveness of PCMH qualities for provider office and patient on <ul style="list-style-type: none"> • Clinical Quality • Cost • Patient experience / satisfaction • Provider experience / satisfaction |
| Wellstar Health System Georgia—Atlanta | Active program, start 5/1/2008, initially 12 mo | <u>Convenor:</u> Humana <u>Stakeholder:</u> Wellstar | To test Medical Home model and effect on outcomes, quality and cost for members in fully insured, ASO and Medicare products. Evaluating success of the project based upon clinical, financial and satisfaction measures. | <ul style="list-style-type: none"> • 2 practices; 13 physicians • 5-6 physicians per practice • Internal med, family med • Commercial, other lines • 850 covered lives | NCQA PPC-PCMH, in process | Gap assessment, additional reporting capabilities, and others | PMPM payment based upon potential savings | Internal. Types of data: <ul style="list-style-type: none"> • Clinical Quality • Cost • Patient experience / satisfaction • Provider experience / satisfaction |
| Quality Quest Medical Home Illinois—Peoria and surrounding counties | Under development, start date 2/09 for 1 year | <u>Convenor:</u> Quality Quest for Health. <u>Stakeholders:</u> Quality Quest, OSF Healthcare, Peoria Health Dept, Health Alliance, ACP, Heartland Comm Clinic, Caterpillar | To create a MH model for the tri-county area, including processes, tools, information and payer/employer benefit designs that facilitate delivery of continuous, comprehensive care and managing / coordinating care. Designed to be readily scalable to include additional payers and an effort will be made to involve them. | <ul style="list-style-type: none"> • 3 practices • Number of physicians TBD • Types of practices TBD • Physicians per practice TBD • Business lines TBD • Covered lives TBD | Undecided | Ensure that all participating practices have EMR. Transformation support in the form of process and training assistance may also be provided. | Currently in discussion. The team has examined a variety of models but has not settled on one yet. | Undecided mode of evaluation. Types of data: <ul style="list-style-type: none"> • Clinical Quality • Cost • Patient experience / satisfaction • Provider experience / satisfaction |

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|--|--|---|---|--|---|--|---|---|
| Louisiana Health Care Quality Forum Medical Home Initiative Louisiana—Greater New Orleans, Baton Rouge, Lake Charles, Shreveport | Start 9/07 for three years | <u>Convener:</u> Louisiana Health Care Quality Forum <u>Stakeholders:</u> 3 academic centers; 3 employers / purch; BCBS; health club; home health; LA Medicaid, Children's Svs & Health Dept; VA; 5 prov / hosp; 2 medical societies; 3 coalitions / inst. / advocates | To lead evidence based QI initiatives to improve the health of the people of Louisiana. The Committee formed to promote adoption of PCMH system of care. In January 2008, the LHCQF board adopted the Joint Principles of the PCMH and NCQA standards. Focus in 3 areas: <ul style="list-style-type: none"> A learning collaborative for clinics and practices in LA working to meet the NCQA standards Working with employers through the LHCQF's Education & Outreach Committee to develop benefits package that will support medical home provision of services through private insurance On Dept of Health and Hospitals Technical Advisory Group; monitoring / advising the Dept on development of Medicaid waiver Provider Service Networks based around medical homes | <ul style="list-style-type: none"> >500 physicians 1-300 physicians per pract Internal med, family med, pediatrics Medicaid Managed Care, Other 1,200,000 covered lives | NCQA PPC-PCMH | Kickoff May '08 featuring national and local leaders as presenters. "The PCMH in Louisiana Spring 2008 Progress Report" & "Medical Home Toolkit published / distributed. Provide educational resources to local practices through regional workshop & info sharing in a learning collab network. EHR adoption being promoted thru implementation of a CMS Demonstration project to provide enhanced reimb. to 100 small to medium size practices statewide and technical support to up to 200 practices. HIT Summit is scheduled for Nov 2008 geared to assist practices to move on with HIT tools. | Benefits package design with payment incentives to be developed | Undecided |
| Maine Multi-Payer Patient-Centered Medical Home Pilot | Start early 2009 for 3 years | <u>Convener:</u> Maine Quality Forum, Quality Counts, ME Health Mgmt Coal <u>Stakeholders:</u> Anthem BCBS, CIGNA, Harv Pilgr, MaineCare, 6 med soc., Community H Centers | First step in statewide implementation of PCMH model Working with all major private payers and MaineCare to develop alternative payment model that recognizes the infrastructure and system investments needed to deliver primary care in accordance with the PCMH model and rewards practices for demonstrating high quality and efficient care. Ultimate goal is to sustain and revitalize PC to improve health outcomes for all Maine people and to reduce overall health care costs. | <ul style="list-style-type: none"> 10-20 practices 30-50 physicians 1-5 physicians per practice Types of practices TBD Commercial, Medicaid, Managed care bus. lines 30-50,000 covered lives | NCQA PPC-PCMH Will ask interested practices to complete MHIQ as self-assessment prior to submitting NCQA PPC-PCMH | Support participating practices through participation in a PCMH learning collaborative and practice coaching | Undecided | Evaluate pilot using comprehensive approach that includes <ul style="list-style-type: none"> Nationally recognized measures of quality, efficiency, patient-centered measures of care That reflect IOM 6 aims of quality: safe, effective, timely, efficient, equitable, patient-centered |
| Aligning PCMH Stakeholders in Michigan | Michigan PC Consortium convened 4 PCMH stakeholder meetings between 4/08-10/08 to lay groundwork for collab / alignment around PCMH in Michigan. | <u>Convener:</u> Michigan Primary Care Consortium (MPCC) <u>Stakeholders:</u> MPCC members, PC professional assoc's, insurance companies, health plans | Enlist stakeholders in participating in a pilot opportunity. MPCC convened a series of PCMH meetings, sponsored Improving Performance in Practice (IPIP) program and invited multiple stakeholders to hear speakers from CO IPIP and Commonwealth Fund As F/U, MPCC convening a series of mtgs for payers & professional assoc to create a PCMH definition, metrics and practice recognition process for MI to: <ul style="list-style-type: none"> Decrease burden that would be imposed on practices through each payer creating a PCMH plan using different assumptions and requirements Lay foundation for future consideration of multi-payer pilots and/or other collaborative work Once group attains consensus, products will be widely distributed to additional stakeholders for input and consensus-building. | <ul style="list-style-type: none"> Types of practices TBD Lines of business TBD | NCQA PPC-PCMH PCMH recognition process developed by BCBSM as part of its Provider Group Incentive Program likely a recognition option. | MPCC-sponsored Improving Performance in Practice Program (IPIP) will assist practices achieve PCMH recognition through <ul style="list-style-type: none"> Learning collaborative experience Implementing process improvement change package On-site coaching by industry trained and loaned experts in quality and process improvement. In addition to engaging 30 practices in 2008 and 100 in 2009, IPIP plans to develop local/regional support for ongoing quality and process improvement in practices. | Undecided | Undecided |
| Patient-Centered Medical Home Vermont Springfield, St. Johnsbury, Rutland, Chittenden County | Active 7/1/05 | Blue Cross and Blue Shield Vermont | Pilot Pay for Quality Program that is aligned with The Chronic Care Model and the VT Blueprint for Health. P4Q pilot program started in 2005 with diabetes and was built off of the structure of the NCQA Diabetes Physician Recognition Program. Maryland participation in P4Q program requires proactive adoption of practice infrastructure changes derived from Health System component of Chronic Care Model. | <ul style="list-style-type: none"> 16 practices 86 physicians 1-32 physicians per pract Internal medicine, family medicine, pediatrics Commercial 15,000 covered lives | Aligned with Chronic Care Model and Vermont Blueprint for Health | Practices may use BCBSVT tools and services to satisfy program entry requirements, or use enhanced funding to support development of their own infrastructure and systems. | Increased reimbursement available for office-based E&M, consultations, preventive medicine & counseling codes. Enhanced reimb applies to all the practices pts, not just those with select chronic conditions. | Evaluation is based on quality improvement at pilot sites using relevant HEDIS measures <ul style="list-style-type: none"> Clinical Quality Patient experience / satisfaction Provider experience / satisfaction |

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|--|--|---|--|--|--|---|---|--|
| Blue Cross Blue Shield of MI: Physician Group Incentive Progr (PGIP) Michigan | Start 2005 until mid 2010 | Blue Cross Blue Shield of Michigan | To reward medical groups for infrastructure improvement to measure & improve care of patients with 4 chronic illnesses. Initial pool based on 0.5% of physician payment. Current program is for PPO. 1% of physician payment is set aside. Provider payment is based on perf improvement, degree of physician participation, and collaborative efforts. Pilot focused on Physician Organizations (POs) because major goal is to catalyze & facilitate development of organization systems of care. BCBSM is using incentives, aggregated among physicians in POs, to support infrastructure development, allowing each PO, and each physician office, to build component capabilities of PCMH model as best they see fit, given the state of their own practice at the outset. As physicians' offices reach reasonable minimum capability with PCMH domains of function, BCBSM will begin to alter payment. | <ul style="list-style-type: none"> • 35 practices • 6471 physicians • Internal medicine, family med, pediatrics, other • Commercial business lines • 1,700,000 lives covered | BCBSMI-recognized <ul style="list-style-type: none"> • Infrastructure (PCMH domains of function) • Perf on Evid-Based Care Measures • Attributed Pop. Use Rates (generics, ER, IP, Imaging) • Patient Experience of Care (mini-CAHPS survey) | Learning collaboratives for providers Incentives to physicians that meet goals towards "initiative tasks" before functioning as a MH Rewards for PGIP service-specific initiatives at improved results level Rewards for New PCMH activities, then higher level of reimbursement for office-based E&M codes to physicians designated by BCBSM as a PC-MH | T-Codes for practice-based care mgmt, incl <ul style="list-style-type: none"> • Services by RN, dietitian, diabetes educatpr, MSW, clinical pharmacist, respiratory therapist • Patients with care plan in medical record and dx of persistent asthma, COPD, CHF, diabetes, CAD, major depression. <p>In mid-2009 begin impl of differential E&M reimb (10% higher) for practices that meet BCBSMI criteria for Basic PCMH.</p> | University of Michigan—Center for Healthcare Research and Transformation Types of Data to be Collected: <ul style="list-style-type: none"> • Clinical Quality • Cost • Patient experience / satisfaction • Provider experience / satisfaction <p>Effectiveness measured by increased access to care/decreased fragmentation of care, reduced cost and use, improved health care processes and outcomes, increased satisfaction (patients/providers)</p> |
| CIGNA and Dartmouth-Hitchcock (D-H) PCMH Pilot New Hampshire; multiple locations | Start 6/1/08 and ongoing | <u>Convener:</u> CIGNA HealthCare <u>Stakeholders:</u> CIGNA, D-H Clinic | Improve quality, affordability and patient satisfaction with care through collaboration and aligned incentives. Three key components: <ul style="list-style-type: none"> • Clinical information • Clinical collaboration • Blended payment model | <ul style="list-style-type: none"> • 5 practices • 391 physicians • Internal medicine, family medicine, pediatrics • Commercial Medicaid • Over 17,000 covered lives | NCQA PPC-PCMH NCQA application in progress. D-H is currently in a CMS Group Physician Practice demo project, which allows it to develop capabilities to participate in this pilot, including case mgmt, enhanced access and information-driven care. | Internally driven, in coordination with CIGNA provided reporting. CIGNA provides D-H with lists of identified high-risk patients according to mutually agreed upon criteria. D-H provides "embedded case management services"—i.e., a nurse who helps coordinate care of the patient with goal of improving quality and reducing avoidable ER visits & hosp for this high risk group & others. CIGNA also provides D-H feeds of "gaps in care" where issues such as med compliance or needed preventive care to addressed at pts next visit. Clinical collaboration between CIGNA and D-H encourage patient access to key programs. | <ul style="list-style-type: none"> • Enhanced care coordination fee • Reward for performance model | CIGNA HealthCare--types of data to be collected: <ul style="list-style-type: none"> • Clinical Quality • Cost • Patient experience / satisfaction |
| NH Multi-Stakeholder Medical Home Pilot New Hampshire | Start 1/09 with payment start of 4/09 going 2 yrs from payment start | <u>Convener:</u> New Hampshire Citizens Health Initiative <u>Stakeholders:</u> NH Inst Hlth Pol & Pract; Ctr for Med Home Impr; DH Med Centr; Elliot Hosp; Dartm Med School; Anthem/Wellpoint; CIGNA, Harv Pilgr; CO ClinGuideI Collab | Design and implement a reimbursement system that values, prescribes and rewards medical care that is tightly coordinated and of superior quality & efficiency. Initiated 1/08 as joint effort of all NH carriers and representatives of clinical, public policy and academic communities. An outgrowth of the Reimbursement Work Group, whose goal is to Focus is adult PC across independent, hospital-owned and FQHC settings. Research questions are: <ul style="list-style-type: none"> • If payers & providers invest in PCMH, can it create value (defined by cost savings or higher quality)? • Will there be sufficient value created to cover investment costs? • What metrics are best correlated to value creation? | <ul style="list-style-type: none"> • 5-10 practices • Number of physicians TBD • 2-5 physicians per practice • Internal medicine, family medicine, other • Commercial, other business lines • 30,000 covered lives | NCQA PPC-PCMH Level 1 Recognition to participate in the pilot. Further use the Adult Medical Home Index to assess degree of medical homeness. | Transformation support is anticipated. A model for support & ongoing collaboration through the Center for Medical Home Improvement has been developed, but not yet funded. | <ul style="list-style-type: none"> • Prospective care mgmt fee for commercial and possibly Medicaid population. NHCHI recommendation is a midpoint of \$4 PMPM, tiered across NCQA levels. • FFS includes payment for care plan oversight & traditional services. • P4P component based on QI and cost savings outcomes prescribed in design. | Evaluation design in development. Anticipate quasi-experimental design w multivariate analysis. Process measures, traditional utilization mgmt meas, preventive & AQA/NQF measures. <ul style="list-style-type: none"> • Clinical Quality • Cost • Patient experience / satisfaction • Provider experience / satisfaction • Registry/biometric data, provider, patient & staff satis.; process meas related to change in the degree of medical homeness.. |

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| Project name, location | Project status | Sponsors / conveners | Purpose / focus / questions | Expected / actual practices / populations | Medical Home recognition | Methods / transformation support | Payment model | Evaluation / Results |
|--|---|---|--|---|---|--|--|--|
| Patient-Centered Medical Home—Diabetes Mgmt North Dakota—Fargo, rolling out statewide | Start 9/07 for 2 years | Convener: Blue Cross Blue Shield of North Dakota Stakeholders: BCBSND, MeritCare | Care is provided in a comprehensive integrated manner at these sites. Cost and quality of care information is carefully monitored. Expansion of prior 2005 diabetes disease mgmt project. Now involves patients with diabetes, hypertension and coronary artery disease. Has expanded from one IM site to three IM sites and one FP site. The number of patients has increased from 200 to 1,100. | <ul style="list-style-type: none"> 4 practices 21 physicians 3-7 physicians per practice Internal medicine, family medicine Commercial business lines 1,100 BCBSND insured chronic disease patients in the practices | Practices expected to: <ul style="list-style-type: none"> Review pt history by the care team Develop a care plan Track care needs Educate pts on self-mgmt techniques Ongoing communic with DMN to ensure med adherence, preventive testing and better self mgmt | BCBSND provided study clinic with a small grant and agreed to share average cost savings from first year. EMR enhancements have been made. | <ul style="list-style-type: none"> A disease management fee allowed on an annual basis Payer has agreed to share demonstrated savings with the provider group. Savings are anticipated, based on a decrease in ER utilization and decrease in hospital admissions. The prior project for diabetes demonstrated \$520 PMPY savings. | Internal evaluation of cost & quality <ul style="list-style-type: none"> Clinical Quality Cost Patient experience / satisfaction Provider experience / satisfaction Reduce inpatient admissions & ER visits; Increase patient compliance with diabetes guidelines; Improve patient self-mgmt skills; reduce future health care costs. Measures: Percentage of members- <ul style="list-style-type: none"> A1C levels below 7.0; LDL levels below 100 mg/dl BP below 130/80mmHg; Tobacco-free Age 40-75 on aspirin therapy |
| MediQhome Quality Project: Patient-Centered Advanced Medical Home Quality Improvement Initiative North Dakota--will include BCBSND providers in contiguous counties of MN, SD, and MT. | Start 2009 for 3 years | Convener: Blue Cross Blue Shield North Dakota Stakeholders: BCBSND, MDatacore Inc, Open to all providers | To expand previous MHP focused on diabetes management: a \$5.2M project Involves deployment of a web-based patient-centered information support and decision to all PC physician offices across the state. Providers reimbursed for use of the portal. Care suites being developed for diabetes mellitus, hypertension, coronary artery disease, asthma, ADHD, chronic heart failure, preventive cancer screening, and immunizations. Multiple clinical info points are tracked based on information primarily from physician records. Care opportunities are reported through the portal directly to the providers. Near-real-time reporting is done that compares the practice performance on standard quality measures between peers. | <ul style="list-style-type: none"> 10 practices 800 physicians 2-400 physicians per practice Internal medicine, family medicine, pediatrics, other Commercial, other business lines Anticipate 650,000 patients in PCMH 40-60,000 chronic disease patients from BCBSND expected to be enrolled | Practices expected to: <ul style="list-style-type: none"> Supply data to portal Use portal for updated info about their patients Modify practices to enhance quality performance. | Technology is supplied at no charge. Each provider is responsible for arranging the download of information to the tool. A series of "best practice" and "lessons learned" discussions are planned after the program starts. | <ul style="list-style-type: none"> Care Management Fee (CMF) allowed on 6-mo basis. FFS system currently in force. Providers reimbursed for use of web-based info portal | Internal evaluation of cost & quality. Outside evaluation being considered <ul style="list-style-type: none"> Clinical Quality Cost Patient experience / satisfaction Provider experience / satisfaction Reduce inpatient admissions & ER visits; Increase patient compliance with diabetes guidelines; Improve patient self-mgmt skills; reduce future health care costs. Measures: Percentage of members- <ul style="list-style-type: none"> A1C levels below 7.0; LDL levels below 100 mg/dl BP below 130/80mmHg; Tobacco-free Age 40-75 on aspirin therapy Will analyze laboratory, EMR, registry other data. |
| CDPHP Patient-Centered Medical Home Pilot (Capital District Physician's Health Plan) New York—Albany | Start 5/22/08 for 3 years. Practice redesign underway and new payment methodology begins 1/1/2009 | Convener: Capital Dist Phys Health Plan (CDPHP) Stakeholders: CDPHP, TransforMED, Comm Care Physicians, CapitalCare Medical Gp | To create a new PC reimbursement methodology that is sustainable & scalable. Hypothesis being tested is whether aggregate savings associated with better health outcomes and lower utilization is sufficient to fund the enhanced compensation to a PC physician and provide a surplus to the plan. | <ul style="list-style-type: none"> 3 practices; 18 physicians 3-10 physicians per pract Internal medicine, family medicine, pediatrics Commercial, Medicare Advantage, Medicaid Managed Care, Other 35,000 covered lives CDPHP to begin as "virtual all payer" pilot offering bonuses for quality outcomes for all pts (commercial & govt) of pilot practices, not just CDPHP pts. | NCQA PPC-PCMH We anticipate that NCQA PPC-PCMH Level 3 designation is necessary but not sufficient and will add additional practice requirements in future. | Partnered with TransforMED to lead our pilot practice through their transformation efforts. | Testing a new payment model based on <ul style="list-style-type: none"> Risk-adjusted comprehensive payment Potential for a significant bonus. | Evaluation by Chief of Division of General Internal Medicine, Brigham and Women's Hospital Medical Director of Clinical and Quality Analysis, Partners Healthcare <ul style="list-style-type: none"> Clinical Quality Cost Patient experience / satisfaction Provider experience / satisfaction |

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|---|--|--|--|--|---|--|---|--|
| EmblemHealth Medical Home High Value Network Project NYC and surrounding counties | Start 2008, recruitment completed by 7/08, for 2 years | <u>Convener:</u> EmblemHealth <u>Stakeholders:</u> EmblemHealth (form. Group Health Inc), Health Plan of NY | To determine whether provision of enhanced payment and support for redesign and care management results in improvement. 1. Greater transformation of supported practices to medical homes and 2. Better performance on measures of quality, efficiency, and patient experience Than in comparison practices. | <ul style="list-style-type: none"> • 38 practices randomized into experimental and control groups • 150 physicians • Majority small/solo practices • Internal medicine, family medicine • Commercial, Medicare Advantage, Medicaid Managed Care • 20,000 covered lives | NCQA PPC-PCMH PPC-PCMH and supplementary questions used to determine medical homeness of participating practices for payment purposes PC-PCMH data also used for evaluation purposes. | Three support components: <ul style="list-style-type: none"> • Data—Practices to receive quarterly reports on performance on clinical quality, efficiency & patient experience measures. • Redesign support—Practices to receive intensive, individualized, practice redesign technical support • Care management staff support—nurse care mgr support projected at .2 FTEs for each 200 HIP/GHI members in participating practice Up-front costs: <ul style="list-style-type: none"> • Participating practices not responsible for cost of NCQA PPC-PCMH recognition process, which is paid by evaluation grant funds from the Commonwealth Fund. • Use of an EMR by participating practices is not required, but special pricing arrangements have been made with specific EMR and hardware / infrastructure vendors. | Three part payment model: <ul style="list-style-type: none"> • Fee-for-service • Care mgmt payment equal to \$2.50 PMPM for a practice fully functioning as medical home with eligible patient pop. of average care mgmt need. • Specific care mgmt amount depends on level of care mgmt need of practice population, practice medical homeness score (the PPC-PCMH survey & supplemental questions) and pt experience • Performance-based pay—equal at maximum to \$2.50 PMPM for each member identified on the practice member list. Specific amount earned depends on practice results on performance measures relating to quality, efficiency, patient experience. | Evaluation by Center for Translating Research into Practice and Policy at the Univ of Connecticut Health Center (funded by Commonwealth Fund) <ul style="list-style-type: none"> • Clinical Quality • Cost • Patient experience / satisfaction Clinical quality process & outcome data at practice level using data is based on HEDIS specifications and those used in CMS Physician Quality Reporting Initiative. Efficiency data using medical claims is used to produce practice-level calculations of savings consisting of a risk-adjusted ratio of expected to actual episode costs. Patient experience data to includes measures of overall satisfaction, access, physician communication and perceived ability to self-manage. |
| New York Hudson Valley P4P / Medical Home Project (THINC-RHIO) New York: Mid-Hudson Valley | Start 2008 for 5 years | <u>Convener:</u> THINC RHIO <u>Stakeholders:</u> Aetna, CDPHP, MVP, Anthem-Wellpoint, Hudson Health Plan, United HC-Empire plan for NY employees, IBM, Hanaford, Taconic IPA, MedAllies, MassPro, IPRO, ViPS, TransforMED, WeillCornell Med College | To implement innovative programs to improve quality and reduce cost of health care in the Hudson Valley. <ul style="list-style-type: none"> • Facilitating diffusion of electronic health record (EHR) implementation in offices practices of the Hudson Valley. • Offering a strategic approach to pay for performance (P4P) among payers and providers across Hudson Valley to serve as model for New York State. • Bringing together multiple health plans that service Hudson Valley region. Using standardized measures agreed upon by providers & payers, project will provide perf incentives from multiple payers to providers. • An added financial incentive for private practice physicians who implement and reach Level II of NCQA's PPC-PCMH recognition system for physician practices. | <ul style="list-style-type: none"> • 100 practices (est.) • 500 physicians • 1->100 physicians per practice, average of 4 • Internal medicine, family medicine, pediatrics • Commercial, Medicare Advantage, Medicaid Managed Care • App. 1 million | NCQA PPC-PCMH. Level 2 recognition required for additional structural payment | Funding from the RHIO will supplement physician EMR subscription fees to cover basic EMR costs, including software, software maintenance, implementation, training and support. The RHIO and physician organization will both provide funding to cover transformation services and support provided by MedAllies, MassPro, IPRO, Transformed. The physician organization will cover NCQA fees and provide administrative support needed for NCQA submission. In 2007, the IPA helped over 400 physicians in New York's Hudson Valley obtain NCQA-PPC recognition. | Under the NYSDOH P4P grant, THINC RHIO can match health plans dollar for dollar to a total of \$1.5 million dollars. Therefore, the maximum bonus for the total pool of participating physicians will be \$3M. Incentive payments to include 2 components to be paid at conclusion of the pilot: <ol style="list-style-type: none"> 1. An outcome component based on process & outcomes measures from aggregated admin data received from health plans participating in project (20%) 2. A structural component by achieving Level 2 NCQA PPC-PCMH recognition (80%). | Evaluation by Weill Cornell Medical College. <ul style="list-style-type: none"> • Clinical Quality • Cost • Patient experience / satisfaction • Provider experience / satisfaction Clinical data will be collected from EMR and chart reviews. Utilization data will be derived from aggregated claims data. Patient and provider surveys will be done throughout the evaluation. |
| Cincinnati Medical Home Pilot Initiative Cincinnati, N. Kentucky | Start 12/1/2008 for 12 months | Humana | Continue to test the Medical Home model and the effect on outcomes, quality and cost for members in fully insured, ASO and Medicare product types. Evaluate success based upon clinical, financial and satisfaction measures. | <ul style="list-style-type: none"> • 4 practices; 15 physicians • 3-5 physicians per practice • Internal med, family med • Commercial, Medicare Advantage, Other • 5,000 covered lives | NCQA PPC-PCMH | Gap assessment, additional reporting capabilities, etc. | PMPM payment based upon potential savings | Internal evaluation. <ul style="list-style-type: none"> • Clinical Quality • Cost • Patient experience / satisfaction • Provider experience / satisfaction |

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|---|--|--|--|--|--|--|--|---|
| Greater Cincinnati Aligning Forces for Quality Medical Home Pilot Ohio/ Kentucky (Partner CO) | In planning phase, start spring 2009 for 2 years | <u>Convener:</u> Health Improv Collab of Greater Cincinnati <u>Stakeholders:</u> UnitedHC, Anthem / Wellpnt, Humana, HealthBridge | Evaluating the effectiveness of the PCMH | <ul style="list-style-type: none"> 12-15 practices Number of physicians TBD Range in practices TBD Internal medicine, family medicine Commercial, Medicare Advantage 30,000 covered lives | MCQA PPC-PCMH | TBD | <ul style="list-style-type: none"> Fee-for-service Care management fee Quality incentives | Currently working with a pilot in Denver to secure research expertise from Harvard with funding from the Commonwealth Fund <ul style="list-style-type: none"> Clinical Quality Cost Patient experience / satisfaction Provider experience / satisfaction |
| Southeastern Pennsylvania Rollout of the Chronic Care Initiative | Start 5/08 for 3 years | <u>Convener:</u> Gov. Office of Health Care Reform <u>Stakeholders:</u> 7 health plans, 3 health syst, 3 med soc, IPIP | Implement the Wagner Chronic Care model in stages in all PC practices across the State. The Chronic Care Commission, created by Governor, crafted a strategic plan that is led by the Governor's Office of Health Care Reform with strong collaboration by providers, payers, professional organizations. Incorporates NCQA PCMH standards as validation that practices are transforming care delivery to effectively manage chronically ill patients. | <ul style="list-style-type: none"> 32 practices 149 physicians 1-10 physicians per practice Internal medicine, family medicine, pediatrics Commercial, Medicare Advantage, Medicaid Managed Care, Other 230,000 covered lives | NCQA PPC-PCMH. Used as validation tool showing that practices have transformed care delivery to the Chronic Care Model | Partnered with the Pennsylvania chapter of Improving Performance in Practice (IPIP) to provide Practice Coaches and a web-based patient registry to the practices. | Payments are made for <ul style="list-style-type: none"> Infrastructure needs Incentives to achieve Levels 1,2 and 3 of PCMH standards | Evaluation / measurement areas: <ul style="list-style-type: none"> Clinical Quality Cost Patient experience / satisfaction Provider experience / satisfaction Other |
| Rhode Island Chronic Care Sustainability Initiative (CSI-RI) | Start 10/1/08 for 2 yrs | <u>Convener:</u> RI Office of Health Ins. Commissioner <u>Stakeholders:</u> 3 health plans, Medicaid; 3 med soc; 9 prov / gps, Comm Health Cntrs, 1 BehH gp; RI AHEC, Hlth Dept, Hum Svcs, RI Qual Partners; employers / purch; Univ Foundation | Test new payment systems along with training & mentoring for nurse care management & practice improvement. The result of a 2-year, broad multi-stakeholder process, funded by a grant from the Center for HealthCare Strategies to the RI Office of the Health Insurance Commissioner. All Rhode Island payers except FFS Medicare participate. | <ul style="list-style-type: none"> 5 practices 28 physicians 3-8 physicians per practice Internal medicine, family medicine Commercial, Medicare Advantage, Medicaid Managed Care, Other 28,000 covered lives | NCQA PPC-PCMH Level 1 in 6 months, level 2 in 18 months | Insurers funding dedicated, on-site nurse care mgr for each pilot site, who will see patients of any / all insurers. As a condition of participation, practices and care managers will receive training and mentoring through the RI Department of Health and RI Quality Improvement organization | <ul style="list-style-type: none"> \$3 PMPM for all patients based on standardized attribution methodology that is standardized across all commercial payers Direct-to-practice payments by health plans for Nurse Care Manager salary and benefits—as a member of the practice, based in the practice, seeing patients of any kind from all insurers Traditional FFS | Evaluation by Harvard School of Public Health <ul style="list-style-type: none"> Clinical Quality Cost Patient experience / satisfaction Provider experience / satisfaction Practices will report quarterly from an EMR or electronic registry on clinical measures for diabetes, coronary artery disease and depression. |
| Memphis Multi-Payer Patient-Centered Medical Home | Planning in process, target date possibly 1/1/09 for one payer | <u>Convener:</u> Memphis Business Group on Health <u>Stakeholders:</u> All major local insurers; local hospitals; ACP, Univ of Tenn; Health Memphis Common Table | To develop a multi-payer approach to PCMH in Memphis area. Because there is no predominant payer in most PC practices, a multi-payer demonstration is essential to transformation of typical PC practice into a Medical Home. Most PC practices are small groups of 2-5 physicians—with no large PC group. The Memphis Business Group on Health held two summit meetings and organized discussions with employers, internal medicine physicians, family medicine physicians, nurses, and all major commercial insurers in the area. Support for Medical Home concept has been obtained from all involved. The next step is to facilitate the advancement of contracts from the insurers and to assist in the reorganization of PC practices to implement principles of the Medical Home. | <ul style="list-style-type: none"> No practices enrolled to date Number of physicians TBD by insurance contracts 2-5 physicians per practice Internal medicine, family medicine Commercial, Medicare Advantage Covered lives TBD | NCQA PPC-PCMH Undetermined how to increment the medical home principles and who will pay for NCQA recognition if required | TBD | TBD. Discussions have included: <ul style="list-style-type: none"> Coordination payments at PPM Fee-for-service for face-to-face Payments for phone and e-mail communications to patients P4P payments | TBD <ul style="list-style-type: none"> Clinical Quality Cost |
| Texas PCMH Demonstration Project | Being developed | <u>Convener:</u> TX Chapter Am College of Physicians | Questions TBD. <u>Stakeholders:</u> 4 medical soc; Tx Health Qual Inst; Tx Dept Health Svcs; Medicaid-CHIP; 5 health plans, HealthDialog (over-under use), employers | <ul style="list-style-type: none"> Number and practices TBD Physicians TBD | TBD | TBD | TBD | TBD |

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State / public-sponsored demonstration projects (from National Partnership for women and families—side-by-side summary of state medical home programs (8/08); available from PCPCC website, www.pcpcc.net; supplemented with info from state websites

| State / name | Project status | Population | Purpose / focus / questions | Standards | Methods / transformation support | Payment model | Evaluation / results |
|---------------------------------|---|---|---|---|--|--|--|
| Alabama "Patient 1st" | Primary care case management program, in place since 2004 | All Medicaid beneficiaries except disabled and elderly | <p>More than 420,000 Alabamians currently participate in Patient 1st, a primary care case management (PCCM) program operated by the Alabama Medicaid Agency.</p> <p>The program was approved by the Centers for Medicare and Medicaid Services (CMS) in August 2004 and includes expanded technology and tools to help doctors and other health professionals better manage the increasing cost of health care while promoting better care for Medicaid patients.</p> <p>Providers must agree to act as primary care giver for patient.</p> | <ul style="list-style-type: none"> • Provide primary care and patient coordination services • Provide / arrange for 24-7 PC services, consultation, mgmt or referral, emerg. medical conditions • Establish / maintain hospital privileges or arrangement for hosp admissions • Maintain unified patient med record • Arrange referrals for medically necessary services not provided directly; document in med record • Care according to standards of appointment availability. | <ul style="list-style-type: none"> • To earn "enhanced management fees," providers must complete 3 training modules on health literacy, medical home, and Medicaid. • Includes "In-Home Monitoring," a complementary program allowing Patient 1st enrollees with certain chronic conditions such as diabetes and hypertension to monitor their conditions at home by transmitting readings into a centralized database. • Has very consumer oriented patient handbook with clear statement of rights, including access to family planning, and responsibilities | <ul style="list-style-type: none"> • Multi-component case mgmt fee, maximum of \$2.60 PMPM. Elements of fee include use of health info technology • Regular Medicaid fee for specific medical service • Also share in savings realized by state from program. | Certain measures required. Patient 1st Primary Medical Providers (PMPs) receive a quarterly Profiler Report with summary info on a PMP's panel for 12 month period of time only for pts assigned to a PMP's panel |
| Colorado | <p>Law (SB 07-130) enacted 2007. Implementation ongoing.</p> <p>State currently offering providers assistance with care coord / case mgmt.</p> <p>Pilot program underway (2008) with 24 providers and 1000 children</p> | Children enrolled in state Medicaid and Child Health Insurance programs | <p>Legislative definition: "A practice that verifiably ensured continuous, accessible, and comprehensive access to and coordination of community based medical care, mental health care, oral health care, and related services for a child."</p> <p>Responsible for:</p> <ul style="list-style-type: none"> • Health maintenance and preventive care; anticipatory guidance • Acute and chronic care • Coordination of meds, specialists, and therapies • Provider participation in hospital care • 24-hour telephone care. | <p>More detailed standards require:</p> <ul style="list-style-type: none"> • Same day appts if needed • Provider and staff encourage family participation in health care decision making • Medical record sharing with other providers if family authorizes • Practice has a continuous quality improvement plan | State providing website for consumers to see provider credential and record of any complaints. | <ul style="list-style-type: none"> • Pay providers higher fee for comprehensive well child visits • Additional payment to providers meeting medical home standards being considered | Will be required |
| Illinois Health Connect | Primary Care Case Management Program Began in 2007. | All Medicaid beneficiaries except those in HMO | <p>Goals of Illinois Health Connect are to:</p> <ul style="list-style-type: none"> • Improve the quality of health care • Reduce the usage of the emergency room for routine medical care • Improve access to care through the availability of a provider network and expansion of providers • Provide the most appropriate and cost-effective level of care | <p>Provider signs addendum to standard Medicaid physician participation agreement and promises to:</p> <ul style="list-style-type: none"> • Serve as patient's primary care provider • Have hospital privileges or arrangements for admission • Makes referrals to specialists • 24/7 coverage • Office hrs of at least 24 hrs/week (solo practices) or 32 hours/wk (gp practices) • Follow recognized preventive care guidelines • Manage chronic disease <p>Enrollees will be assigned a PCP if they do not choose one. Complementary disease management program available for chronically ill beneficiaries, currently targeting children with asthma and disabled adults health care</p> | <ul style="list-style-type: none"> • State provides special secure web portal to support PCP and grant access to patient roster. • Beginning 5/2008 will also give patient's Medicaid claim history and 7 years of immunization data. • Beneficiaries under 21 may Obtain preventive from approved local health dept, school-based clinics, and women's health care providers without PCP referral | <ul style="list-style-type: none"> • \$2 PMPM per child, \$3 for parent, \$4 for elderly or disabled • Regular FFS fees. • Bonus for meeting or exceeding national 50th HEDIS percentile in: <ul style="list-style-type: none"> -Immunization -Devel. screen -Asthma mgt. -HbA1C -Mammograms -Well child visits | <p>Provider profiling, not publicly reported, using 20 HEDIS and HEDIS-like measures, viz:</p> <ul style="list-style-type: none"> • Child immun, lead testing • Asthma/diabetes care • Well child / adoles care, • Prenatal freq / timeliness • Depress, cervical CA screen • Adult access to prev care • Rate of ER visits & ambul care sensitive hospital visits <p>Calculates statewide benchmarks</p> |
| Iowa | Section of an omnibus health reform bill (HF 2539) which became law May 2008 | All state residents Begin with Medicaid | <p>Provider leads team of individuals at the practice level who collectively take responsibility for ongoing health care of patients.</p> <p>Provides or arranges for care by other professionals; care coordinated with community.</p> <p>Medical home system would support both public and private programs, although implementation would begin w/ Medicaid program.</p> | <p>NCQA voluntary recognition process or similar system to demonstrate practice has capacity to provide patient-centered care consistent with medical home model</p> <p>PCP can be:</p> <ul style="list-style-type: none"> • MD who is family pract, GP, peds, internist, OB-GYN • Advanced nurse practitioner • Physician assistant • Chiropractor | Legislation envisions Statewide medical home system that offers care coordination, data collection and analysis, other assistance and monitors quality | <p>Allows gain sharing & quality incentives</p> <ul style="list-style-type: none"> • Reimbursement to be studied by state depts. and recommended to insurers & state progr administrators. • Assumes care management fee will add on to FFS. • Recognizes value of IT. | <p>Voluntary engagement in performance measurement & improvement.</p> <p>Measures to be specified by dept. For children, suggest</p> <ul style="list-style-type: none"> • Immunization • ER use • Well child and oral health utilization rates. |

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| State / name | Project status | Population | Purpose / focus / questions | Standards | Methods / transformation support | Payment model | Evaluation / results |
|---|--|---|---|---|---|---|--|
| Massachusetts | Required in omnibus healthcare quality Improvement law (Senate 2863) Aug 2008. Implementation turns on availability of funds and federal approval of payment structure. | Medicaid beneficiaries who enroll in planned pilot project | Practice must provide care using a medical home model that coordinates care across health care system and the patient's community. | Detailed standards to be developed by state agency. | New law creates state quality and cost council that will determine what performance measures and cost information all providers would be required to submit to the state. Data would be reported on consumer web site. | Payment should reward quality & improved patient outcomes. To be developed by state Medicaid agency. | Annual project evaluation, to be submitted to legislature, to include: <ul style="list-style-type: none"> • Cost savings • Health care screen rates • Outcomes and hosp rates for patients with chronic illnesses. |
| Minnesota | New law in May 2008. Medical home standards and new payment system to be developed by state DHS and Dept of H. | Medicaid, SCHIP and state funded program for uninsured | All health care homes must: <ul style="list-style-type: none"> • Offer patient ongoing long term relationship with clinician, including advanced practice nurses and PAs • Provide care coordination • Enhance patient/family participation in decision making • Ensure use of HIT | More detailed standards for general purposes (col 2) under development (2008-09) | Providers must participate in health care home collaborative re QI | <ul style="list-style-type: none"> • Per person pmts for care coordination, adjusted for patient care complexity • Providers might also quality for separate, add'l quality incentive pay • Care coordination fees funded from savings in other segments of medical programs, including HMO capitation fees if necessary | Required measures: <ul style="list-style-type: none"> • Quality • Resource use / cost of care • Patient experience Particular measures to be specified by state executive branch agencies. |
| Community Care of North Carolina | In place since 1998; Statewide since 2002. Expanding to disabled & elderly populations | All Medicaid beneficiaries except elderly and disabled. 13 networks and 784,000 recipients | Can medical homes and physician-led networks improve care, enhance access, and decrease overall costs? Community Care of North Carolina has physician-led networks that rely on medical home model to save costs & improve quality. Practices agree to participate in state's primary care patient coordination system (Carolina Access) and provide, direct, and coordinate the health care and utilization of health care services of practice enrollees. | Patients must choose a doctor or medical home Physician practices have to meet criteria such as 24 hr access, ability to collaborate with other providers, and capacity to serve as a single access point for patients. All necessary medical services must be provided directly or authorized and arranged through the practice. Balanced effort around quality and cost savings | Practice is supported by regional CCNC entity that assists in care management, identifies resources, collects performance data, and provides feedback to practice. | <ul style="list-style-type: none"> • Regular FFS payments • PMPM fee, currently \$2.50 • CNCN network clinics also receive \$3 PMPM fee for each beneficiary. For capitation of \$5.50 / mo per Medicaid pt, practices use evidence based guidelines for at least 3 conditions, track tests & referrals, measure and report on clinical & service performance. | Significant savings to Medicaid for ER and hospitalizations. (Arvantes 2007) <ul style="list-style-type: none"> • Saved \$60M in Medicaid in 2003 and \$140 M in 2006 compared to historical FFS benchmarks • Program spent \$8.1M between 7/02 and 7/03, saving more than \$60M over historic costs. • In second year \$10.2M spent but \$124M saved. • 2005 savings grew to \$231million. |
| Oklahoma Health Mgmt Program | Began in January 2008 | Selected Medicaid enrollees with chronic conditions | Direct care management support (RNs) for identified Medicaid beneficiaries with high-risk chronic conditions | | Assistance to providers in practice redesign to improve quality and efficiency. | No additional payment to providers. Nurses hired by state | |
| Oregon | Health Oregon Act of 2007 required Oregon Health Fund Board to develop health reform plan for Oregon with specific action steps & timelines. Final Board report due 11/08. | Beneficiaries of public programs but available to others | Program should incorporate a health benefit model that promotes primary care medical home. Draft report (9/08) of Oregon Health Fund Board recommends Medicaid and SCHIP recipients be enrolled in an "integrated health home" (IHH) which reflect the patient-centered medical home model of team-based care, care coordination, and stress wellness, prevention and disease management. Board report envisions IHH model adoption by other publicly funded program, including employee benefits, and private insurers | | | Board recommends diverse IHH payment strategies be tested, including mix of: <ul style="list-style-type: none"> • Fees for direct services\ • Risk-adjusted bundled payment for care integration. • Payment should also be tied to quality of performance. | Board recommends structure for collecting data from all providers on: <ul style="list-style-type: none"> • Quality • Cost • Outcomes Make publicly available. |
| Pennsylvania Chronic Care Initiative (Also in PCPCC pilot listing) | First pilot located in SE PA region in May 2008. Plan is to replicate in other regions of state. | All beneficiaries enrolled in practices in regional Medical Home pilots | Patient-centered medical home practice redesign initiative focusing on patients with chronic conditions. Initial focus: diabetics and pediatric asthma. | Model based on the four professional society Joint Principles for Medical Home. Rewards for PCC-PCMH recognition | Initiative lead by Governor's Office of Health Care Reform Practice redesign Work being funded by foundation grant | Increased reimbursement for <ul style="list-style-type: none"> • Attaining PCC-PCMH recognition • P4P Funding supplied by participating insurers, including state Medicaid program. | Will be required |

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| State / name | Project status | Population | Purpose / focus / questions | Standards | Methods / transformation support | Payment model | Evaluation / results |
|---|--|---|--|--|---|--|---|
| Rhode Island Connect Care Choice | In operation in some parts of state since 2007 | Medicaid Adults not also eligible for Medicare and not enrolled in Medicaid HMO | Primary care practices who agree to help coordinate care | | | <ul style="list-style-type: none"> Multi-component PMPM based on enhanced svcs Special additional PMPM for case managers for identified high risk pts Both in addition to regular FFS reimbursement | |
| Vermont Blueprint for Health | Implementation of two pilots underway in 2008 | Patients with chronic Conditions enrolled in public programs Private providers encouraged to participate | For patients with chronic conditions—ongoing integrated care plan using HIT, decision-support tools, and patient self-management | PCP (board certified, if applicable) who provides ongoing support, oversight and guidance to <ul style="list-style-type: none"> Implement an integrated patient care plan Use HIT & clinical decision support tools Encourage patient self-mgmt | Providers supported by community-based care coordination teams (CCTs) to assist with care coordination and patient education, including workshops to enhance patient self-mgmt abilities. Vermont launched Healthier Living Workshops across state to help residents with chronic illness learn techniques for managing their condition and working with providers in partnership. | <ul style="list-style-type: none"> Care management fees Incentive payments for demonstrated compliance with established clinical protocols. Recommended fee structure under development. | Data analysis and reporting structure to evaluate pilots under development |
| Washington Chronic Care Management Program | Program started 2/07 | Medicaid beneficiaries Identified as high-risk and not enrolled in HMO | | King County Care Partners Network determines provider participation | State contracts with King County Care Partners, a provider network in King County to provide medical home State contracts with AmeriChoice to provide care management services for clients outside King County and help client find medical home | Fee structure negotiated with state under contract | |
| Washington | Multi-stakeholder workgroup mandated by Child Health Act of 2007 | Children enrolled in public programs | Practice where patient receives medically appropriate medical, dental and behavioral services and community support services, using team approach. | Qualifying primary care practices must be willing to adopt medical home models as defined by the dept. of social and health services in Nov 2007 report to legislature. | | Various methods under discussion; likely to include specific incentives tied to quality improvement | Measures identified that will reflect impact of medical home such as: <ul style="list-style-type: none"> Childhood immunization rates Well-child visits |

Other demonstration projects to note

*Cited in NY Medical Home Evidence Policy Statement: "Advancing Medical Homes: Evidence-based literature review to inform health policy. 11/07 NYS Primary Care Coalition and in Helle & Fernandopulle (2007)

| Project name | Organization | Population | Purpose / focus / components | Lessons learned | Transformation support | Payment model | Evaluation / results |
|--|--|--|---|--|---|---|--|
| Geisinger Health System care model redesign Paulus, Davis, and Steele (2008) Continuous Innovation in health care: Implications of the Geisinger Experience, Health Affairs. 27:9, 2008 pp. 1235-1246 | Geisinger is integrated delivery system in central and NE PA with 700 physicians across 55 clinics and several hospitals and a health plan | 2.5 million who are poorer, older, and sicker than national benchmarks. | Medical home: Geisinger's Personal Health Navigator: Improving care coordination and optimizing health status for each person. <ul style="list-style-type: none"> 24/7 PC and specialty access Nurse care coordinator in each site Predictive analysis to identify risk trends Virtual care mgmt support, personal care navigator EHR access to pts, providers, care mgrs—lab results, self-scheduling, secure email, EHR-based "snapshot reports" on single screen Chronic disease care optimization—to embed automatic, standard care workflows and delegate tasks Acute-episode care: Geisinger ProvenCare for CABG and other | Lessons learned: <ul style="list-style-type: none"> Align incentives Clinician leaders paired with business leaders Diverse stakeholder participation Functional EHR system Perf measurement and data mining Clinical translation—rapid application of existing knowledge Linking financial & quality budgets Willingness to take risks and experience failure | <ul style="list-style-type: none"> Highly collaborative design Specific targets for redesign Clinical business case Multiple specific improvement methodologies Monthly performance reports on quality and efficiency. Trends and improvement opportunities identified | Practice-based payments <ul style="list-style-type: none"> Monthly \$1800 paid per physician to recognize expanded scope of practice Monthly transformation stipends of \$5000 per thousand Medicare members to the practice to finance additional staff, extended hours, infrastructure Incentive pool based on actual/expected costs of care if quality indicators are met | Early results from first-year experience at 2 pilot sites are promising: <ul style="list-style-type: none"> 20 % reduction in all- cause admissions 7 % total medical cost savings. Based on this early favorable experience and participants' assessment of a strong clinical impact, program is undergoing expansion to ten additional Geisinger sites and one non-Geisinger practice to cover more than 25,000 Medicare Advantage and FFS Medicare patients. Whether this favorable trend continues and in additional sites, remains to be seen. |
| Boeing Ambulatory Intensive Care Unit (AICU)* | Boeing in Seattle, with Mercer Health & Benefits, Renaissance Hlth, Virginia Mason Med Ctr, Valley Med Ctr, Everett Clinic | 700 of sickest and costliest patients identified by Renaissance Health's predictive modeling program | Sickest and costliest patients to "opt in" to medical home model to improve affordability, quality, pt. experience (Helle & Fernandopulle 2007) Focusing on team health care and linkage of specialists. At heart is dedicated physician & nurse with 24/7 access via email, phone, home visits. Intensive care management—high tech, high-touch proactive care to identify and coordinate medical needs early and support change in patient behavior | Clinics had to develop a team-based support infrastructure and develop a "shared care plan" for each participating patient | | <ul style="list-style-type: none"> Traditional FFS Case rate ranging from \$25-\$100 | Very early preliminary results / observations <ul style="list-style-type: none"> Costs of project 9.9%; saved 46.8% over historic costs Clinic physicians were on salary and did not personally share in case rate but anecdotes suggest they were supportive anyway Patient incentives to opt in were necessary |

This attachment contains summaries of a meaningful but manageable sample of Minnesota work on Health Care Home.

This is a body of Minnesota work done gathered for the ICSI Medical Home Forum (July 10, 2008), with health plan and public system information updated in the fall of 2008. This body of thought, evidence, and experience is regarded here as a manageable source from which to create a snapshot of the current state of the art in health care home in Minnesota.

Recall that “state of the art” means *“The highest level of development . . . of a device, technique, or scientific field, achieved at a particular time . . . usually as a result of modern methods. . . the most recent, and therefore considered the best; up-to-the-minute.”* The summaries shown here represent broad efforts of Minnesota groups seriously trying to design, evaluate, implement, and test health care home concepts from clinical, systems, financial, and policy perspectives “in real time” and hence can be considered demonstrations that among the primary or at least most articulate sources of current Minnesota “state of the art”

Hopefully this will be regarded as an expandable document capable of incorporating new and updated Minnesota source material as it emerges.

The purpose of this table: To facilitate comparison of how this sample of Minnesota groups is acting on medical / health care home concepts. The leftmost column has to do with how groups look at medical home goals or desired outcomes. As columns move toward the right, the content becomes more operational and more about learnings, results and challenges.

1. Read across the rows to get quick snapshot of how a particular group characterizes its work
2. Read down the columns to get a quick sense of common themes or differences in how groups think about each dimension, moving from goals to more operational and challenges

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Glossary for terms in columns

| | |
|------------------------------|--|
| Goals / ends / measures: | The desired end state of affairs and how you will know you have achieved it |
| Governing principles: | Values, rules, philosophy, beliefs, ethics that guide choices among alternative ways to reach the end goals |
| Components / functions: | Major design chunks, building blocks, systems, functional capacities (“headings”) |
| Processes, tools, methods: | Specific subsystems, processes, or tools that perform the work of the major building blocks (“key details”) |
| Financial / payment methods | Approach, method, rules, aspirations regarding financial or reimbursement model |
| Leadership / change methods: | How you build internal capacity to induce change—shifting methods and culture in a sustainable fashion |
| Starter population: | The patient population this is designed to benefit—or the current starter population in your trajectory toward full implementation |
| Unique aspects to feature: | Distinguishing features of the work, or history / situation of organization that bear on the work and that helped you succeed |
| Learnings / successes: | What you have learned or have noted as being promising or successful |
| Barriers / challenges: | What has been blocking your way or is a big challenge to meet |

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Provider groups

| | Goals / ends / measures | Governing principles | Components / functions | Processes, tools, methods | Leadership / change mgmt | Starter population | Unique aspects to feature | Learnings / successes | Barriers / challenges |
|---|---|--|---|--|--|---|--|--|---|
| Family Health Services Minnesota | <ol style="list-style-type: none"> 1. Improved patient outcomes as measured by MN community measurement 2. High patient satisfaction and scores 3. High payor satisfaction | <ul style="list-style-type: none"> • Patient-centered • Patient choice of provider, time, and place • Continuity of care • Group access to records • Transparency and "value" as it applies to patient care and outcomes | <p>EMR implementation to:</p> <ul style="list-style-type: none"> • Visualize, track and review data • Hold physicians and clinics accountable for their quality • Allow patients to choose where and when and by whom they want to be seen <p>Care management</p> | | <p>Our entire leadership team attended and endorsed culture change to lead a culture of quality</p> | <p>180,000 East metro patients; diverse socioeconomic mix & ages from birth to geriatrics</p> | <p>Physician owned and run</p> <p>No deep pockets</p> <p>Groundwork over 2-3 years of changing to a culture of quality is beginning to allow us to be nimble and make changes more easily</p> | <ul style="list-style-type: none"> • Improved pt. outcomes on community measurement • High pt. satisfaction scores • Local as well as leadership champions • Needs buy-in by all members of organization | <ul style="list-style-type: none"> • Resistance to change • Financial investments (time and money) as an independent group |
| Fairview | <ol style="list-style-type: none"> 1. Improved outcomes reported through MNMCM 2. Improved patient engagement & experience 3. Eventually reduced use of resources to achieve these ends | <ul style="list-style-type: none"> • Transparency of outcomes & high expectations • Quality committee to set and lead initiatives • Upper executive leadership putting emphasis on quality as "Job 1." | <ul style="list-style-type: none"> • Care managers working with rosters of patients to make sure people are getting the f/u they need. • Team approach to care including MTM, CDE's, nutrition counseling • Preventative care reports (CA screening, immunizations) to get upstream from when patients need more expensive care • ICSI guideline/standards used if available | | <ul style="list-style-type: none"> • Cultural adaptive work offered through a year-long course of > 60 hours for medical leadership • Representative quality committee leading system decisions at a local level | <ul style="list-style-type: none"> • All populations • Current projects in a number of chronic diseases incl DM, CKD, depression • Plans / aims are active towards a comprehensive home for the entire panel of patients seen at the clinic. | <p>P4P allowed an earlier movement towards changing perspectives and attention than might not otherwise have been possible.</p> | <p>Everything takes longer than expected. (Turning the tanker takes time.)</p> | <ul style="list-style-type: none"> • Revenue sources concentrating on RVU basis for payment makes it difficult to support resources needed for a medical home. • Needing to get multiple payers moving together (including government) makes innovation difficult. |
| HealthPartners Medical Group | <p>Goals and measures related to the Triple Aim of</p> <ul style="list-style-type: none"> • Experience • Health • Affordability. <p>Plan to apply for the NCQA Medical Home recognition, with its measures</p> | <ul style="list-style-type: none"> • Our Care Model Process (standardized, reliable work flows and the right person doing the right job) as the foundation of our medical home. • Team care with cultural readiness for providers and RN's to delegate to others on the care team • A clarified Provider Compact setting cultural norms necessary for this transformation | <ul style="list-style-type: none"> • Care for the full population of patients - not only those with chronic diseases. • Standardized workflows apply to all patients. • Care coordination / care mgmt / disease mgmt • Resources for patient self-mgmt and connections to the community. • Looking at different roles doing different work, such as RN's, pharmacy and leveraging CDE's. | <ul style="list-style-type: none"> • EMR (Epic) is essential • Care Model Process components • Care manager support for patients with depression in DIAMOND project in two initial clinics and plans for spread to additional clinics. • Started in-depth work on "between visit" care. This component of our Care Model Process involves many elements of medical home such as coordination of care and case mgmt or disease management | <ul style="list-style-type: none"> • Established approaches to implementation and spread. • In past two years extensive work to clarify our Provider Compact setting cultural norms necessary for this transformation. • Cultural ability for those in professional roles (providers, RN's) to delegate to others on the care team. | <p>All of our patients</p> | <ul style="list-style-type: none"> • Working closely with our health plan in development of medical home components, criteria, etc. • This is also a forum for collaboration on payment reform principles aimed at supporting care that improves pt. satisfaction and quality while reducing overall costs. • Have already worked on establishing the foundation of care redesign that will support medical home. | <p>Gained knowledge of standardization, reliability, delegation, teamwork and broad implementation in our Care Model Process work.</p> | <ul style="list-style-type: none"> • A medical home should provide outstanding care & service to all patients—as demonstrated by top performance in not only clinical outcome measures for chronic diseases, but in measures for preventive service, satisfaction and care coordination • This requires care model redesign, not just additional resources for care mgmt. • For the medical home concept to be successful and sustainable, a reduction in the total cost of care must also be an outcome. • Testing new processes in a functioning model and payment system that may not recognize the medical home model will be more challenging. |

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| | Goals / ends / measures | Governing principles | Components / functions | Processes, tools, methods | Leadership / change mgmt | Starter population | Unique aspects to feature | Learnings / successes | Barriers / challenges |
|---|---|---|--|--|--|--|---|--|---|
| Marshfield Clinic | <ol style="list-style-type: none"> Improved Access. Goal for Primary Care is same day access for 3rd next available long appointment Increase in quality measures currently recorded and reported. Increases in physician, staff, and patient satisfaction. Ability to increase panel size in Primary Care. Reduction in cost per unique patient from current levels. A more consistent and efficient work flow across the system | <ul style="list-style-type: none"> Increasingly standardized care processes Increasing emphasis on team care. Shifting unnecessary or clerical work from the provider such as inventorying meds, allergies, past medical history, family history, and social history. | <ul style="list-style-type: none"> A team approach to care delivery incl physicians, allied providers, nurses, MA's, and appt coordinators Adult planned visit for chronic disease and preventive exams Previsit planning to assure pt. needs are addressed and met thru preparation of both the patient and care team. Have all necessary info available at time of visit so that change of treatment, if needed, can be done in the face-to-face visit. Secure messaging and e-visits, as health care will depend less on face-to-face visits in the future | <ul style="list-style-type: none"> More clinical info gathered and recorded by MA staff input directly into the structured document for the event, which is viewable and modifiable by provider. The prevention screen allows appt. coordinators, nurses, and MA's to act on patient needs by protocol. The wellness summary provides written and graphical summation of pts recommended tests and interventions as well as run chart of measures such as weight, BP, lipids, A1C, etc. and updated medication list. Enhanced portal for e-visits and secure communication | <p>As process moves from pilot to full implementation, leaders will need to be clear that this is not a passing fad but is the way we deliver healthcare, and that it is a dynamic process with changes and improvements on a continuing basis.</p> <p>Marshfield Clinic's culture has traditionally allowed a fair amount of independence and has not demanded strict adherence to centralized processes.</p> <p>Face to face visits with the physician doing much of the care delivery has been the norm. Transitioning to a team process will challenge some.</p> | 374,663 | | <p>Giving an overview of the process to physicians and staff well ahead of the actual teaching of the new process allows time for the recipients to get more comfortable with the change rather than everything changing for them when they first are exposed.</p> <p>Having a broad based group of people involved in the development of the process lends more credibility than if a small cloistered group developed the process.</p> | <ul style="list-style-type: none"> A challenge is to overcome the culture of physician autonomy that can stand in the way of redesign. In this time of budgetary challenge, it is difficult to find ways to pay for infrastructure needed to provide care in a non face to face context since our revenue comes from visits. As payers transition to models of care management fees and increased fees for P4P, this will improve, but in this transition time, it is difficult to fund patient activators, panel managers, etc. |
| Mayo Clinic Primary Care Internal Medicine | <ol style="list-style-type: none"> Panel size per FTE. Performance on MNCMP measures. PMPM costs. | <ul style="list-style-type: none"> A population focus. Team based care that allows stratification of care based on patient need. Care and appointments that match services with actual patient needs | <ul style="list-style-type: none"> Multidisciplinary care teams Advanced triage at the team level (not centralized) Pre-order/planned care Stratified chronic disease management Shared patient decision making Virtual consultation <p>Keys:</p> <ul style="list-style-type: none"> Development of a team-based model of care that allows stratification of care provided based on pt. need. Development of a system of care that matches services with pt. needs. Traditional short/long doctor's office appts are inadequate to address the diverse needs of our pts. Neither our sickest, most complex pts, nor our healthy, busy pts. are well served by this model | | <p>The most critical element for us has been a change in payment structure off of an RVU based system.</p> | Employees, dependents, retirees of Mayo, Medicare MA and privately insured community patients. | Most ideas have been borrowed or modified from others. | <p>Advanced triage</p> <p>Team based scheduling (versus centralized scheduling) to get the right patient in the right place with the right provider at the right time.</p> | <ul style="list-style-type: none"> Inertia. "RVU" mentality IT limitations. |
| NorthPoint Clinic / Health and Wellness Center | <ol style="list-style-type: none"> All participants with a care plan An annual visit (PE) An accurate registry A patient-centric and relationships-centric practice | <ul style="list-style-type: none"> Patient-centric & relationship-based More holistic--not siloed into disease and condition-specific models, e.g. special needs, DM, depression, etc. Care team for a broad panel of patients, each of whom brings individual concerns, issues, cultural context, disease, conditions. Medical home based on "primary care" team care, not specialized team care. See our pts in context of their world to optimize their health, by getting to know pt's stories and who they are (which takes time and relationship). | <ul style="list-style-type: none"> Care coordinator Registry Language-specific data base (paper) for mgmt Care plans | Registry and recall process seem most important | <p>Participated in MDH MN Academy of Pediatrics pilot.</p> <p>Leadership eventually to support the staffing needs to avoid "limping along"</p> | Our pt panel: Currently piloting a children with special needs medical home. | <p>Community health workers available</p> <p>Home visits by providers for some.</p> | <p>Having a dedicated care coordinator with designated time; we tried to do this "on our own" on the fly, and things did not get done.</p> | <p>Time and resources.</p> <p>It is challenging for a team to care for many different conditions that may require specialized skills. So do we need primary care medical home teams and specialty teams, just as our medical system has developed?</p> |

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| | Goals / ends / measures | Governing principles | Components / functions | Processes, tools, methods | Leadership / change mgmt | Starter population | Unique aspects to feature | Learnings / successes | Barriers / challenges |
|--|---|---|--|---|--|--|--|---|---|
| Park Nicollet Clinic / Health Services | <ol style="list-style-type: none"> 1. Increased sense of partnership with professionals 2. Improved care team satisfaction with communication and coordination of care 3. Improved efficiency of care 4. Improved child/youth outcomes: decrease in ER visits, hospitalizations, and school absences. 5. Improved clinical outcomes for adults related to chronic conditions 6. Improved systems outcomes: decreased duplication, decreased fragmentation | <ol style="list-style-type: none"> 1. Collaboration & communication with all providers, especially with the primary care provider using the expertise of the entire team. 2. "Enhanced Access": care available through systems such as open scheduling, expanded hours, and new options for communication between pts their personal physicians & practice staff. 3. Is satisfying for families, providers and staff 4. Coordinates services 5. Uses a team approach for care of chronic conditions, which includes planned, proactive visits. | <ol style="list-style-type: none"> 1. Physician-directed medical practice—the personal physician leads a care team of individuals who collectively take responsibility for ongoing care of the patient. 2. Partnership between patients and primary healthcare team. 3. Care Coordination Care coordinated across all elements of health care system 4. Registries to better understand patient populations 5. Routine use of health information technology and systematic follow-up, including the use of patient registries. 6. Evidence -based medicine and clinical decision-support tools 7. Comprehensive Care plans developed for patients with complex or chronic conditions. 8. Performance measures on quality, patient and staff satisfaction and cost of care. 9. Quality improvement processes | <p>Leadership is essential to the success of the Medical Home, understands the principles related to medical home, and enforces the need for this as a priority for the organization.</p> <p>Leaders must find resources including care coordinators and IT resources to better understand the patient population.</p> <p>A Care Coordinator Manager has been hired and is in process of developing job descriptions, workflows, standard work and educational processes related to the Medical Home.</p> | <p>Initially piloting pediatrics at two sites—children with special health needs including chronic physical, developmental, behavioral or emotional conditions.</p> <p>Developing criteria for Internal Medicine pilot with initial focus on chronic conditions</p> | | <p>Families add a great deal of knowledge to the team.</p> | <p>Finding resources continue to be challenging</p> <p>Care coordination takes time, and currently we have no reimbursement for this skill</p> <p>IT needs also require additional time and resources</p> | |
| Dept of Family Medicine and Community Health, U of M, UMPPhysicians | <ol style="list-style-type: none"> 1. Reaching publicly reported quality targets 2. Improved patient satisfaction scores 3. Growing practice base and volume via more satisfied pts appreciating the "value" we offer. 4. Be profitable without "gaming" payment system with highly remunerated gadgets, MRIs, lasers, etc. Pay our way by doing better, more efficient, effective, personalized primary care! | <ol style="list-style-type: none"> 1. Work together collaboratively to improve 2. Change is our friend—if we participate actively vs. react to commands passively. 3. Teams solve problems better than individuals. 4. We can restore a sense of "fun" to our work. | <ol style="list-style-type: none"> 1. Continuity—to 70% of care from defined PCP- now 50-65%; everything gets better with improved continuity. 2. Chronic care improvement—diabetes and asthma with focus on community measurement targets. We are improving but more slowly now after an initial "surge". 3. Prevention, well child visits, and reaching some goals on health screening for children. Improvement but with fewer full successes with adults. 4. Smoking cessation docum., Quit Programs, diabetes ed. visits, pharm. visits for med. coordi. 5. Mental health integration moving forward for DIAMOND implementation. | <p>Among many details:</p> <ol style="list-style-type: none"> 1. Meet at least monthly and sometimes more often to improve continuity, chronic care, prevention, integrated mental health, and keep making headway with culture change that supports improved quality. 2. "Lean" model changes on near horizon. Tools include: <ol style="list-style-type: none"> 1. Improved EMR documentation templates 2. Streamlined work role redefin. 3. Focus on pre- and post-visit contacts with pts to improve care | <ol style="list-style-type: none"> 1. Step one was joining the ICSI and IHI quality programs. Creating a Quality Culture was a turning point. 2. Improved "meeting hygiene"—clearly improved meeting management has increased our productivity when we meet on any topic. 3. Building quality and team building methods into almost all group activity has helped us create more effective and satisfying teamwork. | <p>Our entire population: 2/3 government pay patients in Medicaid and Medicare plus a mixture of private insurance covered patients in 4 indigent urban Twin Cities locations that are also residency training sites</p> | <p>We are striving to transform our practice while also training the next generation of family physicians.</p> <p>Serving the underinsured and uninsured is a special challenge when we reach across cultures and languages.</p> | <p>It helps to have a shared language of quality, teamwork, mission.</p> <p>Managing our interactions carefully to improve our impact of taking time together is possible.</p> | <p>We're still paid primarily for more visits and not for providing overall care coordination, or health mgmt.</p> <p>Complex patients are most at risk for being "left behind" or being "eased out" of a practice that needs to "hit quality perf. targets".</p> <p>Teaching takes time not normally rewarded via payment models--whether teaching pts or health professionals.</p> <p>Long-term benefits of engaging pts. as active partners and sharing our evolving wisdom about new care models is "donated" effort not easily seen or rewarded from afar.</p> <p>Now facing "Initiative fatigue" and frustration with secretarial burden on MDs with EMR tasks.</p> |

Institute for Clinical Systems Improvement
Health Care Home State of the Art: Minnesota framework. 12/30/08

| | Goals / ends / measures | Governing principles | Components / functions | Processes, tools, methods | Leadership / change mgmt | Starter population | Unique aspects to feature | Learnings / successes | Barriers / challenges |
|-------------------------------------|---|--|---|--|--|-------------------------|---------------------------|--|---|
| CentraCare Medical Home Team | Open, transparent organization that allows patients to be seen at facility of choice with preference of physician and time | | Implemented EMR In process of implementing • Registry • Care mgmt for chronic disease • Open Access • After hours extended care | Began in 2005 with remarkable improvements using PDSA method—starting small, checking that change is an improvement scaling up from there, revising as needed | | Pediatrics | | | |
| CentraCare Clinic | <p>1. Improvement in Medical Home Family Survey (part of MN Med Home Learning Collab) and Medical Home Index</p> <p>2. A full time budgeted Care Coordinator</p> <p>(Data is processed for us by Wilder Foundation as part of the Collaborative. We use it to guide future directions and review the effectiveness of our effort)</p> | <p>Partner with families as keystone of the effort—a source of many ideas for improvement—and a dimension we could not create on our own.</p> <p>Ongoing QI as part of what we do in the clinic</p> <p>Teamwork among all stakeholders is essential to bring about change.</p> <p>Positive reinforcement all along the way</p> | <p>1. Multidisciplinary team (meets weekly) consisting of:</p> <ul style="list-style-type: none"> • Physician champion, • 3 parent partners, • Care Coordinator • Nursing Director • Nurse <p>2. Registry—used by all members of the practice</p> <ul style="list-style-type: none"> • Registry is constantly being worked on by surveying patients when they come in, using the CAHMI screener • The EMR will make this registry more useful • Helpful in scheduling Special Needs pts for longer appt, and calling patients back for Chronic Care visit appointments annually. <p>3. Care Planning—the single most important thing we do</p> <ul style="list-style-type: none"> • Reaches out to Special Needs patients and their families. • Involves the provider and parent • Helpful in communicating with specialists, schools, ancillary medical services such as PT, etc. • The Care Plan is a worksheet completed by the parent, provider, and Care Coordinator finishing it; changes made as needed. • Provided to the family for their use, and available in the EMR. • Annual Chronic Care visit (not physical or Well Child Visit) is used to update, and review patient's care and plans for future. <p>4. Parent Networking Group—strictly parent led and open to all in the community, not just our parents</p> <p>5. Networking with other service providers in the community is ongoing effort—and is never easy, but we strive to improve communication with schools, public health, etc with Lunch and Learns, etc.</p> <p>6. Quality Improvement built into the infrastructure of the clinic.</p> <ul style="list-style-type: none"> • PDSA is basic improvement tool in our practice. Other techniques include mapping of processes, reliability improvement. • Team meetings over clinic-provided lunch weekly on clinic time--with agenda, note taker. Parents meet with us every other week, with stipends paid by the Learning collaborative. • Learning sessions 3 times yearly to share successes & techniques with each other with experienced teams teaching newer teams. | <p>Began in 2005 with remarkable improvements using PDSA method—starting small, checking that change is an improvement scaling up from there, revising as needed</p> | <p>People in leadership in the institution must understand the project and be in full support, or it cannot move beyond minor improvements.</p> <p>Their support is essential to align all the different depts within the clinic that must work together to make improvements happen, such as lab, x-ray, front desk, HR, media, etc.</p> <p>Having an involved physician champion is essential to move the project forward or the energy is lost. As much as possible, improvements must be built into daily working of the clinic, and must not rely on the efforts of one or a few people, or they will not continue to happen.</p> | Primary care pediatrics | Partnership with families | <p>Networking with other providers of services in the community is an ongoing effort—and is never easy,</p> <p>The Care Plan is a timesaver after it is created. All 20 pediatricians started using them and appreciate benefits to themselves and their patients. Other clinics in CentraCare system want to start their own Medical Home processes</p> | <p>Spreading the improvements is a challenge, and the most effective way is to have success that others can see.</p> <p>We have buy-in from Administration, but whenever dollars are needed to proceed, it is always a struggle.</p> <p>Care coordinator position time is now carved out of pre-existing referral coordinator position. Seeking ways to turn this into a full-time dedicated position to Care Coordination, preferably an NP or at least RN level. Care coordinator and transcription all working together to create, to not overburden provider.</p> |

Institute for Clinical Systems Improvement
Health Care Home State of the Art: Minnesota framework. 12/30/08

Public sector: Minnesota Dept of Human Services / Dept. of Health from Primary Care Coordination (PCC): MN Dept of Human Services, 10/31/08, and Schiff (7/08 presentation) Developing Healthcare Home in Minnesota

| Goals / measures | Guiding principles | Provider criteria from Primary Care Coordination (PCC): MN Dept of Human Services, 10/31/08 | Financial / payment method |
|--|--|---|--|
| <p><u>Purpose</u> of the health care reform initiative:</p> <ul style="list-style-type: none"> • Improve the health of Minnesotans • Improve patient and family experience • Redesign care to improve value (quality/costs) <p><u>Key component:</u> Improve PC and chronic care through care coordination & establishment of “medical homes” for MN Health Care Program clients.</p> | <p><u>Principles:</u></p> <ul style="list-style-type: none"> • “Start with the end in mind” and remain focused on what we want to accomplish and what success looks like. • So that all Minnesotans benefit from reforms, aim for market-wide implementation of reformed processes—not just processes for government programs. • Seek & expect unprecedented collaboration among public & private partners as we implement the comprehensive health reform initiative—patients & families, other national and local HCH models, physicians and other professionals, health plans, hospitals, advocates <p><u>Health care home standards must:</u></p> <ul style="list-style-type: none"> • Encourage active participation by the patient / family • Encourage the use of primary care • Encourage “top of the license” practice • Provide ongoing, consistent contact with a clinician • Focus on efficient and effective health care services • Encourage the use of scientifically based health care • Encourage patient decision aids • Ensure the use of HIT / patient registries • Ensure each patient has a comprehensive care plan <p><u>Clinics that choose to be certified</u> must participate in:</p> <ul style="list-style-type: none"> • Training / learning collaborative • QI processes & measures • Patient / family surveys • Data collection • Patient screening and identification | <p>1. Patient-Centered Care Coordination</p> <p>A. The clinic must provide care coordination using staff that:</p> <ul style="list-style-type: none"> • Work in the PCC clinic; have protected time and space set aside to coordinate care; have the authority to delegate care coordination tasks within the practice • Have a broad skill set, including knowledge of medical terminology and cultural competency; ability to prioritize clinical needs and access medical and social service resources beyond their skillset; ability to communicate complex info to patients, families, other providers; knowledge of basic computer skills; knowledge of patient & family centered care <p>B. The clinic must engage patients and/or families in medical care by:</p> <ul style="list-style-type: none"> • Utilizing a care coordination team consisting of: the provider (physician, nurse practitioner, or physician’s assistant); the care coordination staff; other clinical staff as needed • Meeting as a team with the patient and/or family to assess, plan, and manage the patient’s comprehensive health care needs • Using the patient’s and/or family’s preferred available mode of communication to provide expedited access to the Care Coordination team • Including the patient and/or family in shared decision-making • Providing on-call, 24/7 access directly or via a phone triage system to a provider (physician, NP, or PA) with access to the patient’s Registry data (see below) • Providing access to clinic appointments within one working day for acute care issues; providing timely transition planning after discharge from a health care facility • Providing an updated version of the Care Plan (see below) to the patient and/or family at any significant update and at least annually • Communicating with pertinent local social service and community service providers to ensure optimal health and care of the patient • Managing and supporting the patient’s care needs at appropriate intervals as predetermined by the patient’s care plan and acute needs; reviewing care needs at least monthly <p>2. Care Plan: The clinic must create and maintain a comprehensive Care Plan for each patient which:</p> <ul style="list-style-type: none"> • Is developed with direct participation of the patient and/or family • Is provided to the patient and/or family after significant updates • Is updated by the care coordination team per a clinical protocol to ensure continuous relevance at least 1 per 6 mo • Is updated with the patient and/or family at least once every year • Contains, at a minimum: 1) The patient’s chronic diagnoses, allergies, physical status, mobility status, level of independence, activities of daily living (ADLs), instrumental activities of daily living (IADLs), relevant physical findings and labs, ongoing medications, major procedures, durable medical equipment, community and education service providers, specialist partners, family caregivers, patient and family unique communication needs and preferences, specific cultural and language requirements; 2) Unique goals and plans of care for: preventive care (and reasons for deviating from established protocols), chronic care, acute exacerbations of known chronic diseases, plans for care and early contact with the care coordination team during acute episodes, transitions for discharge from hospitalization, end-of-life care and/or advance directives, when appropriate, patient and family unique care needs and preferences <p>3. Registry:</p> <p>A. The clinic must create and maintain a patient Registry database which:</p> <ul style="list-style-type: none"> • Is electronic, searchable, and available within the clinic site • Is used to manage preventive care and chronic disease care for the PCC patient panel • Is available to on-call provider peers and for phone triage systems • Contains, at a minimum, the patient’s name, age, gender, racial/ethnic background, primary language, contact information, family/guardian contact information if applicable, individual privacy or confidentiality concerns, list of diagnoses, allergies, chronic medications, last date of registry update <p>B. The Registry may be a subset of the Care Plan as long as the criteria listed in 3a above are met.</p> <p>4. Quality Improvement:</p> <p>A. The clinic must create an internal Quality Improvement Team which</p> <ul style="list-style-type: none"> • Consists of participating provider, the care coordination staff, at least 2 patient and/or family representatives (if applying as a clinic site, patient and family representation should roughly be in this proportion to the number of participating providers), the clinic administrator, other clinic staff as needed • Meets at least monthly; creates goals for practice and care delivery improvement • Plans, implements, and records results of quality improvement cycles; reviews and measures progress towards goals • Incorporates social service, education, mental health and other community providers when appropriate to meet quality improvement goals <p>B. Representative members of the clinic quality improvement team (providers, care coordinators, and patient/ family representatives) must participate in an ongoing quality improvement training process that teaches quality improvement methodology; shares information and learning between clinic sites through multiple quality improvement cycles; Fosters intra-clinic and intra-system improvement processes.</p> <p>C. Measurement of results: The clinic must survey patients and/or families to measure: 1) satisfaction with care delivery, 2) level of engagement in patient care; provide reports (via existing quality reporting systems or directly to DHS) as determined by the State to assess patient health outcomes and quality of care delivery</p> | <p>2008 Legislation:</p> <p>A. <u>Payment reform and price/quality transparency</u></p> <ul style="list-style-type: none"> • Establishes a single statewide system of quality-based incentive payments to be used by public and private health care purchasers. • Creates a powerful set of tools to compare providers on overall cost and quality of care. This information will be used to create incentives for health care providers to innovate on ways to deliver health care and consumer to use high-quality, low-cost providers. • Promotes transparency and accountability by establishing “baskets” of health care services to more easily compare cost and quality of care across providers. • Convenes a workgroup to develop strategies for engaging consumers <p>B. <u>Health care cost containment</u></p> <ul style="list-style-type: none"> • Requires health care cost savings to be measured against projected costs without reform. • Compared to baseline projections, the health care reforms in this bill are estimated to have the potential for cost savings of about 12 percent by 2015—a potential savings of about \$6.9 billion compared to baseline projections <p>C. <u>Payment restructuring</u></p> <ul style="list-style-type: none"> • The Care Coordination Fee will be based on patient care complexity, incorporating diagnosis(es) social and cultural determinants, predictive modeling. To be developed by 1/1/10 and implemented 7/1/10 or upon federal approval • All health plans must include HCH’s in their networks by 1/1/10 |

Public sector: Rural Health Care Delivery—A New Model. Report for the Rural Health Advisory Committee; MN Dept. of Health Office of Rural Health and Primary Care (by permission of M. Schoenbaum from 11/08 draft)

| Goals / measures | Guiding principles | Recommendations |
|--|---|---|
| <p>Problem: Health care in US needs improvement</p> <ul style="list-style-type: none"> Highly fragmented and episodic. Over-reliance on specialized medical care. Care is often excessive and inefficient. Payment system creating incentives for procedures instead of wellness and prevention. <p>Task of Rural Health Care Delivery Workgroup:</p> <ol style="list-style-type: none"> How can the unique needs of rural Minnesota and its PC system be incorporated into the medical home concept so it will be successful in <i>all</i> parts of the state? Integration of clinic, hospital, long term care and other services are common features of the rural health system. How to build on this structure to stabilize primary care, expand care coordination and address unmet needs for mental health, dental, home care and other community health services? <p>Product: Models and policy recommendations supportive of establishing primary care, integrated systems and interdisciplinary teams as a new model of rural health care delivery.</p> <p>Rural communities and health care home <u>Features supporting health care home success:</u></p> <ul style="list-style-type: none"> Rural physicians trained and experienced in family practice—a strong primary care infrastructure Rural communities are concentrated. Patients are less scattered among multiple delivery systems and have fewer sets of independent systems to navigate Rural care delivery often includes established teams of providers Many rural communities are involved and engaged in healthcare access and delivery <p><u>Challenges affecting rural health care homes</u></p> <ul style="list-style-type: none"> Workforce—declining numbers and advancing age of PCPs, with much rural population in medically underserved areas Care coordination/integration and access to specialty consultation and services over vast geographical areas Technology availability—rural infrastructure under-resourced and behind urban areas. Reimbursement that does not reward PC activities is more challenging for small providers in sparsely populated areas with lower volumes & fragile margins | <p><u>Joint principles of patient-centered medical home</u> (AAP, AAFP, ACP, AOA, 2007)</p> <ul style="list-style-type: none"> Physician directed medical practice; Personal doctor for every patient; Comprehensive; Coordinated and family-centered; Accessible, continuous and high quality; Compassionate and culturally effective; and A payment system recognizing the added value for patients. <p><u>Emphasize integration across the rural continuum of care:</u></p> <ul style="list-style-type: none"> Personal Behavior Emergency and Primary Care Routine Specialty Care Inpatient Care Rehabilitative Services Long-term Care Palliative Care <p><u>Make patient-centered connections,</u> communication, and integration between traditional health care organizations and beyond—within and across these arenas:</p> <ul style="list-style-type: none"> Personal outpatient health services (e.g. clinics, mental health, pharmacy, dental, specialty care) Acute and post-acute care (e.g. inpatient, skilled nursing facilities, home care) Public and community resources (e.g. local public health services, transportation, schools, community education, churches, business) <p>Rural hospitals often assume a coordinating role for community-based care.</p> | <p>Require rural impact assessments on all components of health care reform. Health Reform Act of 2008 requires assessment of the “readiness of the primary care delivery system to implement health care homes for targeted populations with chronic or complex condition, [along with] consumer understanding and readiness in Minnesota for implementation of health care homes” to guide capacity-building efforts for a statewide health care home system. As noted in Health Care Reform: Addressing the Needs of Rural Minnesotans, planning and policy development must be responsive to rural differences in demographics, distance, workforce, and health system characteristics to accomplish policymakers’ health reform goals (ORHPC, 2007). With this in mind--</p> <ul style="list-style-type: none"> Rural populations should be identified as subpopulations to be considered when adjusting payment incentives and other components of health reform Rural health providers should be specifically identified for consideration as standards, criteria, and requirements are developed Rural patients and providers should be actively recruited for inclusion in all community assessments and implementation work groups established <p>Recommendations Regarding Health Care Homes in Rural Minnesota. Health care home concept infrastructure must be inclusive of both urban and rural perspectives on health and care delivery. Patient concepts of health and health care are affected by place of residence and community-level culture and are reflected in health-related behaviors and in how preventive medicine is offered and illnesses are treated (Long, 1993).</p> <ol style="list-style-type: none"> <u>Pursue rural primary care workforce development strategies simultaneously with health care homes development.</u> Robust care teams allow PCPs to provide better care and are more attractive to students considering practice in rural areas. Support Rural Primary Care Clerkships, the Rural Summer Experience for premed students, loan forgiveness programs and similar efforts. The AHECs and Health Education Industry Partnership (HEIP) employ long-term strategies to expand the primary care pipeline by fostering community, educational and health care industry partnerships for local planning, recruitment and retention of health care professionals to rural MN. <u>Establish multiple options for health care home certification.</u> Provider standards to qualify as health care homes must contain enough flexibility to encourage full participation by rural providers, especially small and financially fragile practices. Accountability to goals rather to specific mechanisms should be emphasized to avoid creating barriers to meeting criteria. Recognize that care delivery in rural and underserved areas does not have same workforce capacity, and other factors like underdevelopment of electronic health records or formal quality reporting systems <u>Broaden provider perspective of health care home through education and leadership development.</u> The “Health Care Home Collaborative” created in Minnesota’s health reform legislation will build on the pediatric model of Minnesota’s Medical Home Learning Collaborative established in the early 1990s to focus on children with special needs. The Learning Collaborative provides an educational forum for providers and families to come together, share experiences, and collaborate on health care improvement. <u>Provide for community self-assessments for health care home readiness.</u> Assisting smaller communities to identify existing and additional resources necessary for health care home implementation. Develop a community readiness assessment tool to inventory local services and “knock down silos” to build up connections. Broaden the readiness assessment of the PC delivery system to also assess and capitalize on related community resources such as senior centers, schools, extension educators, rural cooperatives, and churches, all of which frequently play an important informal role in accomplishing continuity in rural communities. <u>Expand infrastructure boundaries of health care home membership</u> to engage pharmacists, dentists, school nurses, local public health and ancillary health care services, such as mental health providers and paramedics. Building a PC base is key to establishing a health care home, yet a distinctive feature of rural settings is the broader scope of practice for PC providers and greater use of midlevel professionals (e.g. nurse practitioners) and technicians (e.g. pharmacy and physical therapy). Family surrogates, such as “care navigators” for patients isolated in smaller, rural communities, could be included as part of the health care home team. <u>Enable equitable participation from small, rural and independent health care providers.</u> Create a “floor” for every provider to ensure a minimal level of reimbursement from participating as a health care home. Establish regulatory parameters that distribute financial benefits and risks among all health care home providers to create greater incentive for small, independent providers to participate. Realign to reimburse for diagnosis and decision-making rather than procedural tasks. Payers will need to begin reimbursing for coordination of care tasks under Minnesota’s 2008 health reform law and envisions that reimbursement of care coordination is based on the complexity of the patient care provided. <u>Provide health care home start-up funding for small, rural providers</u> to take into account the financial instability of the rural health care system. <p>Recommendations for Rural Health Care Delivery Coordination and Systems Integration Across the Continuum. Health care homes is an important development in the delivery of PC but there is still a critical need to support and encourage system level integration or coordination across personal outpatient services, acute and post-acute care, and public and community resources.</p> <ol style="list-style-type: none"> <u>Encourage and support efforts by higher education to offer provider training</u> in team-based, inter-professional care, especially in rural settings. <u>Encourage communication improvements across a variety of sectors--</u>removing barriers for connecting to formal and informal support systems to improve care coordination. <u>Continue statewide initiatives for rural providers to use interoperable EHRs</u> and health info technology, while making technology mandates scalable. Rural providers who do not have EHRs should not be prevented from being able to participate in health care homes or any other new delivery model. <u>Establish and encourage financial collaborations for meeting technology needs.</u> The cost of delivering telecommunication to sparsely populated areas continues to be much higher than urban areas. Rural electric cooperatives are early examples of regional collaboration that led to federal financial assistance for electricity expansion into rural areas that had been ignored by the commercial electric industry. <u>Build upon regional networks, cooperatives, collaborations, and alliances</u> for sharing resources, risks, and talents of all kinds. Provide grants and technical assistance for community-specific, locally-organized, collaborative health care access and delivery planning. <u>Provide planning and financial assistance</u> for innovative and sustainable approaches focused on key, high-need issues <u>Make payment reform a priority</u>—reform that rewards provider collaboration and system integration. |

Institute for Clinical Systems Improvement
Health Care Home State of the Art: Minnesota framework. 12/30/08

Health plans

| | Goals / ends / measures | Stakeholders | Governing principles | Components / functions | Leadership / change methods | Fin / payment model | Starter population | Learnings / successes | | Barriers/challenges |
|--|--|---|--|---|---|--|---|--|--|---------------------|
| Blue Cross Blue Shield of Minnesota | Improvement in the outcomes, leading to a reduction in the cost of care of the patient population being served in the medical home Need assurances that the processes and structures that are being paid for are being used (process measures). | <ul style="list-style-type: none"> Provider Organizations Community Organizations | <ul style="list-style-type: none"> Patient centered (not physician centered but called "patient centered") Patient self-empowered Team based (working at the top of one's license) Primary care based. Care is coordinated. Movement beyond 1:1, face-to-face encounters. | Primary care based. <ul style="list-style-type: none"> Team delivery model to use resources efficiently and at the best level of expertise. Various means of accessing medical home including non-face-to-face and group visits. Care coordination within the home and with community (specialists, hospitals, home health agents, public/parish nurses, etc.). Condition registry for care coordination within the home, tracking and follow-up of gaps in care. A care plan that is patient centered - owned and developed with the patient, family, and all who provide care and support for the patient. | Clinics will have to <ul style="list-style-type: none"> Want to become a medical home Have a champion to lead effort Work hard to make the necessary cultural changes. Specifically: <ul style="list-style-type: none"> Team approach to care Work flow to allow other forms of patient access Coordination of care with other members of health team outside the medical home and with community Develop methods/discipline of identifying gaps in care and reaching out to patients outside office encounter Develop skills to help patients manage their conditions. | Considering using: <ul style="list-style-type: none"> Coordination of care using "G" Codes being developed by CMS. Our P4P program to provide rewards for positive outcomes based on medical home activity | Starting with patients with chronic disease conditions. <ul style="list-style-type: none"> Incorporate preventive services for population. Consider moving to a broader population base depending on how the model works. | <ul style="list-style-type: none"> Different ideas about what the medical home elements are, even when same name used (e.g. "patient centered"). Terms should not only be defined, but put into behavioral terms. A care plan is non-trivial for most practices and resisted by many providers – probably due to lack of understanding of what they are or how to develop). Important to have process measurement to measure progress even early on. However, somewhat difficult and seldom done. Without that, development can move down blind alleys and stall before needed corrections caught leading to frustration, discouragement, and abandonment of efforts. | <ul style="list-style-type: none"> Culture, culture, culture, culture Resources Knowledge / understanding of the elements Doubt in providers, payers, and probably patients that this is important and/or will work. | |
| Preferred One | Decreased ER and hospitalizations | Provider organizations | Team approach to care similar to DIAMOND | Primary care and associated support services. | N/A | Still in development | Patients with chronic disease | Too early | Too early | Too early |

| | Goals / ends / measures | Key stakeholders | Governing principles | Components/ functions | Leadership / change methods | Financial / payment model | Starter population | Learnings / successes | Barriers / challenges |
|------------------------|---|---|--|---|---|--|--|--|-----------------------|
| Health-Partners | Not finalized but will include: <ul style="list-style-type: none"> Measures of quality, drawn wherever possible from MNMCM or other standard sources Patient satisfaction Cost of care Outcomes broadly stated: <ul style="list-style-type: none"> Improvement in patient experience Reliable delivery of best practices in health and health care Reduction in avoidable and unnecessary health care costs Establishment of a sustainable model of primary care services Medical Home should be able to demonstrate better performance on all of these categories compared to non-medical home care delivery. | <ul style="list-style-type: none"> Provider organizations Community organizations Employer groups / purchasers Member/patients MDH/DHS | An easily accessible, comprehensive set of primary care, health, and medical services chosen by the patient, delivered by multidisciplinary teams, coordinated with other providers and health plan initiatives. Key cultural elements/principles include: <ul style="list-style-type: none"> Team based care Systems based approach Effective use of data Effective patient communication and education tools Seamless coordination of services Accountability for clinical quality outcomes, satisfaction, and total cost of care Services delivered to match the needs of the individual patient Evidence based care Comprehensiveness Collaboration between Medical Home and health plans | Senior leadership from medical group and health plan fully engaged in Medical Home topic: <ul style="list-style-type: none"> Incorporating into strategic planning, Sponsoring work to move the concept into operational detail, Considering payment reform options, measurement and accountability, and coordination between health plan and delivery system (owned and contracted). LEAN change management. | Payment model still under development Will have expectations around: <ul style="list-style-type: none"> "Certification" elements Performance on clinical quality, patient satisfaction, and cost of care | All members served by the medical home model. Measures of effectiveness for subpopulations: Patients without chronic or complex disease: <ul style="list-style-type: none"> Reliable delivery of preventive care, Access to convenient acute care, Healthy lifestyles, Satisfaction, etc. Chronic disease, no acute complications: <ul style="list-style-type: none"> Measures above and, Reliable delivery of evidence based care (i.e. comprehensive diabetes measure) Hospitalizations or ER use rates Chronic disease with associated complications / complex disease: Add'l measures such as complication rates. | Too early to cite successes But operations teams in the medical group to take current "Care Model Process" for reliable care delivery as the model for medical home | <ul style="list-style-type: none"> Uncertainty about the concept Aggressive timelines from the legislature and purchasers Current cultures built to deliver based on FFS Challenge of developing payment reform models to match incentives for desired outcomes Perceived lack of readiness to transform Large number of stakeholders Political uncertainties | |

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| | Goals / ends / measures | Key stakeholders | Governing principles | Components / functions | Leadership / change methods | Financial / payment model | Starter population | Unique to feature | Learnings / successes | Barriers/challenges |
|------------------------|--|---|---|--|--|---|---|---|-----------------------|---------------------|
| UCare Minnesota | Still in development Interested in understanding the current state of medical home initiatives in the Minnesota community | <ul style="list-style-type: none"> Provider organizations MDH / DHS <p>Comment:</p> <ul style="list-style-type: none"> Alliance of Community Health Plans Minnesota Council of Health Plans | <p>Not delineated as yet</p> <p>Operationally, we believe there is a significant amount of resources that would need to be invested in clinic infrastructure before the medical home model can be implemented</p> <p>Culturally, we think that there is an underestimation of the effort and resources required to function as a certified, competent medical home.</p> | Basic components are consistent with the 7-9 categories outlined by AAFP, AHIP, and NCQA | <p>Led by two Senior VP's. An internal UCare Medical Home Steering Committee convened to move work forward.</p> <p>Members of our Leadership Team have been participating in a Patient Centered Medical Home Collaborative sponsored by the Alliance of Community Health Plans</p> | Case management / care coordination payment model | Chronic care population. Considering including all UCare members | For three of the past four years, we have provided quality infrastructure improvement dollars to a number of our care systems. Many of their efforts are in areas that could support certification as a medical home. | N/A | |

| | Goals / ends / measures | Governing principles | Components / functions | Leadership / change methods | Financial / payment model | Starter population | Unique to feature | Learnings/successes | Barriers / challenges |
|---------------|---|---|---|--|---|---|---|---|---|
| Medica | <ul style="list-style-type: none"> Outcomes tracking – comparing overall health coaching to overall clinic-based chronic care management Participation measures Process measures Clinical outcomes (i.e. MNCM D5) Patient/member satisfaction Physician satisfaction Increased participation Financial outcomes –reduction in total cost of care <p>Key stakeholders:</p> <ul style="list-style-type: none"> Provider organizations MDH/DHS Community organizations | <ol style="list-style-type: none"> Comprehensive chronic care: <ul style="list-style-type: none"> May prove to be most cost-effective when delivered at point of service Reduces fragmentation in delivery of service Must be member-centric / patient-centered with individual driving interventions. Chronic disease more effectively managed when care integrated Current reimbursement model cannot sustain PC mgmt of chronic disease Culture change Info from the participating clinics Organization leadership critical Improved reporting of variation to providers Public reporting drives changes to get higher scores P4P drives these changes Cultural issues related to team care | <ol style="list-style-type: none"> Senior leadership support Physician support (of varying degrees), meetings / education Team care with care coordinator Wagner's Chronic Care Model integration Pre-visit, post-visit & between visit planning & interventions Registry and tracking tool Active patient education, empowerment, and patient activation Use of and/or development of tools to assist in patient management, education, physician communication Management of EBM guidelines, goals, targets Measurement (participation, process, clinical outcomes, patient satisfaction, physician satisfaction, financial outcomes) Outcomes tracking & reporting Data exchanges between clinic EMR & claims data Health risk assessment linkage Risk stratification / predictive modeling Staff education | <p>Support from CEO, CMO, Network Management, Provider Relations, and physician advisory committee.</p> <p>Openness in discussing changes in reimbursement models, testing various models to find sustainable solution.</p> <p>2008 Healthcare Innovation Award Program – clinics submit applications demonstrating innovative care delivery with opportunity to receive recognition/monetary award.</p> <p>Three Medica staff (2 MDs, 1 Project Mgr) working with individuals on provider side (1 MD, 1 QI Lead, 1 RN / coordinator to be).</p> | <p>Grants to 5 clinic-based chronic care management pilot projects provided through extension of network contract. Lump sum payment upon completion of agreed upon metrics.</p> <p>Considering management fee paid on PMPM, calculated to cover expenses with reasonable profit. Models include</p> <ol style="list-style-type: none"> Incentives for primary care team that: <ul style="list-style-type: none"> Deliver cost efficient care Choose cost efficient specialists/ facilities for referral/ hospitalization, etc Choose cost efficient medications. Possible options for sharing in potential savings based on total cost of care. | <p>Current: All clinic patients with chronic disease/condition.</p> <p>Future: All patients seeking care from clinic/medical home (birth-to-death/ prevention-to-disease)</p> | <ul style="list-style-type: none"> "Grant-funded" pilots designed to assist implementing all/part of Wagner Chronic Care Model via teamwork in primary care office(s). Innovation Award Program Able to evaluate in-house program compared to clinic-based program. Program built on member-centric/ patient-centered principles Launched Health Coaching Program - planning in 2008 to pts with education, self-mgmt, self-empowerment, health system navigation, emotional support, social assistance Move toward internal DM, not external vendors | <ul style="list-style-type: none"> Still in early stages of learning Continue discussions and involve many stakeholders Change management Long time required for intake of patients Some tools cumbersome when put into use Issues of case mix adjustment, managing outliers, understanding which costs may not be in control of the PC team, must be worked through Not a "quick fix" | <ul style="list-style-type: none"> Data sharing – merging clinic data with health plan data Reimbursement/payment systems EMR differences Clinic culture & provider buy-in Trust & team environment Locus of control PCP support & referral Physician engagement Defining difference between diabetic education and care coordination Hiring additional care coordinators when needed "Core group of providers like the "old way" Uncertainty how many patients can be managed by 1 FTE coordinator Payer mix with high government programs Clinical inertia Incorporate Preventive care into acute visits Cultural issues related to team care |

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ICSI DIAMOND initiative: “A medical home for depression”

| Goals / ends / measures | Governing principles | Components / functions | Processes, tools, methods | Leadership / change methods | Starter population | Unique to feature | Learnings / successes | Barriers / challenges |
|---|--|--|--|---|--|---|---|---|
| <p>1. First and foremost is patient activation: Are patients in the program & engaged.</p> <p>2. Patient satisfaction with the program.</p> <p>3. Patient outcomes: Response & remission rates at 6 and 12 mo. Note: Initial 6 month data show 50% response rate and 35.5% remission rate</p> <p>4. Care manager retention and job satisfaction.</p> <p>5. Prim Care Provider and psychiatrist job satisfaction.</p> <p>6. Overall health care effect</p> <p>7. Other clinical outcomes such as fewer admissions or ER visits; productivity and absenteeism in the workplace, etc.</p> | <p>1. Collaborative care model with team approach! This is a culture shift. Providers and nursing staff are used to working independently. Individuals must have a collaborative mindset for the success of the medical home model.</p> <p>2. System and systems approach. It is to help work become more cohesive and collaborative.</p> <p>3. Communication links are set and working.</p> <p>4. Clear job roles and responsibilities. It is about doing your piece of the job that you are most qualified to do and trust that others on the team and the systems common to the team are doing what they are suppose to do.</p> | <p>Four System Components:</p> <ol style="list-style-type: none"> The use of a registry for tracking and follow-up of patient care. The use of evidence-based guidelines for diagnosis, mgmt, and treatments in a standard fashion across providers. The use of a standardized assessment tool for both aiding in diagnosis but understanding patient disease progress and measurement of outcomes. A specific approach to relapse prevention for pts in depression remission <p>Two Care Mgmt roles:</p> <ol style="list-style-type: none"> Care manager—a new role identified as lead on coordinating overall depression care for eligible pts. Also responsible for: <ul style="list-style-type: none"> Frequent contacts, Assessing compliance & knowledge Medication side effects, Patient goal setting, etc. Liaison between PCP and psychiatrist. Consulting psychiatrist <ul style="list-style-type: none"> Connect with CM virtually or face-to-face at PC site 1 / week to review cases Provides educ. to the CM, Advises on tx changes and modifications, etc | <ul style="list-style-type: none"> Scripts Standard intake, follow-up and relapse tools Education to staff, providers and patients regarding the program and clinical care Frequent measurement with fast turn-around and immediate feedback of process and patient outcomes for team success. | <ol style="list-style-type: none"> Steering Committee at oversight level to get program running and supported from high level. Administrative leadership critical for buy-in and support to the program—for building, purchasing, using various infrastructure pieces such as a registry. Leadership champion within collaborative team is vital for ongoing buy-in with all participants, to identify the right people and skills for the right roles on the collaborative team. Local team leadership to provide frequent feedback on measures to admin. leadership for ongoing support or to help overcome challenges. | Specifically adult patients with depression being managed in primary care. | <p>A well-structured and evidence-based approach that is easier for groups to initially buy into.</p> <p>A payment redesign process to support the sustainability of this program and patient outcomes.</p> | <p>Many key learnings are in the previous boxes.</p> <ul style="list-style-type: none"> Identification of key roles that are clearly defined. Teamwork, building relationships between all key stakeholders on a medical home team Don't underestimate the need for those relationships to be built Identify & enhance work flow process so all are comfortable with the process & outcome Work through a patient flow process through your medical home together as a team. It has to be cohesive, not individual silos of care. Patient input is necessary from the start and all the way through. | <p>Continuously gaining buy-in and keeping everyone moving in the same direction.</p> <p>For a medical home to work, you need to have all stakeholders on board who understand and use the program</p> <p>Finances - if the cost is more than the reimbursement, it will be difficult to find and maintain value (value meaning quality and cost)</p> |

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West-Central Minnesota Values Health: A pilot program for covering uninsured and underinsured residents. Includes Health Care Home concepts; from Report to the Minnesota Dept of Health, 12/07

| Goals / ends / measures | Governing principles | Components / functions | Financial model | Healthcare Home Implementation | Program Evaluation |
|---|--|--|--|---|--|
| <p><u>Purpose of Values Health:</u> Improve care outcomes in cost-effective manner for those economically vulnerable. "Care will be coordinated and/or integrated across all elements of the health care system and the patient's community, and will ensure that patients get the indicated care when and where they need and want it, and that it is culturally and linguistically appropriate." (Kuratis, 2007)</p> <p><u>A 5- yr pilot project to</u></p> <ul style="list-style-type: none"> Extend the eligibility reach of the MinnesotaCare program in a 10-county area Provide services to uninsured & underinsured persons of all ages in the community, with special focus on preventing & effectively managing chronic disease and other persistent conditions, particularly persons who have or are at risk of multiple chronic conditions often not effectively managed in current health care system. Repackage the participation cost structure to make it a more affordable health coverage option for a greater number of economically vulnerable uninsured/underinsured residents. <p><u>Stakeholders:</u></p> <ul style="list-style-type: none"> West Central Minnesota Community Collaborative to Cover the Uninsured: Partners from counties, hospitals, local employers, integrated health clinics / physician groups, school systems and a third-party payer, PrimeWest Health Syst. PrimeWest Health, a county-based purchasing plan owned by 13 rural counties in west-central, southwest and northern MN will administer the Values Health program for the Collaborative <p><u>Hypothesis:</u> If individuals, communities, businesses and government work together cooperatively to reengineer the care system, it will be possible to cover the uninsured and to give those with insurance a better value for their healthcare dollar.</p> | <p>Values Health premises:</p> <ol style="list-style-type: none"> The cost of health care should relate directly to the level of health care quality (patient's health care experience and care outcomes). Compensation for health care providers should relate directly to the value of their role in helping a patient maintain wellness or achieve optimal care outcomes in most cost effective manner <p>Values:</p> <ol style="list-style-type: none"> Comparable access to care for economically vulnerable Integration of medical care, mental health care, county public health, county social services, other county resources, school and worksite services Healthcare delivery efficiency through concepts such as healthcare homes, chronic care mgmt, care coordination, EBM, wellness programming Healthcare & provider info to make wise healthcare and purchasing decisions Healthcare financing to reward providers and patients for good outcomes Electronic health info technology Public program coverage optimization to enroll more who are eligible Transparency of finance & operations to all stakeholders Accountability to legislature and stakeholders Portability safety net in event of disenrollment Consumer empowerment in maintaining health and using healthcare, incl HAS Adaptability to a wide variety of urban and rural settings Economic development to promote employment and earnings to reduce dependence on public programs Cost-effective administration to ensure more dollars for health | <p>Integrates proven / emerging concepts for maintaining wellness and achieving optimum care outcomes in cost-effective manner.</p> <ol style="list-style-type: none"> <u>Eligibility and Enrollment</u> <ul style="list-style-type: none"> Extends coverage to economically vulnerable Assertive outreach Multiple points for eligibility determination Values Health memberID and multi-purpose smart card Comprehensive enrollee education on benefits and navigating health system <u>Health Assessment and Screening</u> <ul style="list-style-type: none"> Comprehensive Health Status and Risk Assessments (medical, MH, CD, social, wellness) Physical examination Early identification of health conditions & risks <u>Care Coordination and Service Delivery</u> <ul style="list-style-type: none"> Triage and care coordination pathways Interdisciplinary case management Health Care Home Outcome-based care planning & service delivery Disease management Integrated medical-MH care mgmt / service delivery Evidence-based medicine Individualized wellness / prevention and programming Cooperative integration Centers of excellence Consumer-directed provider choice and service delivery Value-based provider/service utilization decision making Electronic medical records interconnectivity Real-time service tracking (thru smart card technology) Workplace environmental health improvement Provider and member accountability <u>Payment and Financing</u> <ul style="list-style-type: none"> Value-based provider reimbursement Wellness / prevention provider reimbursement Pay-for-Performance Member empowerment & self-respons tools & incentives Health Savings Accounts Multi-share financing (member, employer, comm, state) Dynamic and sliding co-pay and deductible schedules Payer accountability Administrative efficiency | <p><u>A "four-share" approach</u>—using individual, employer, community, state contributions during 5-yr pilot, then phasing out state share for participants whose incomes / assets exceed state threshold for MHCP coverage.</p> <ol style="list-style-type: none"> Individual's financial commitment made in the form of a sliding scale. Participating employers' share would go toward the premium. The community will contribute through fundraising, community benefit commitments, healthcare organizations, and other sources. The state will contribute a portion of the cost of services and part of the costs of research and evaluation of the program. <p><u>State share during pilot phase essential to:</u></p> <ol style="list-style-type: none"> Help offset the costs anticipated with triaging and treating pent-up health care needs of the uninsured Allow the program time to mature in order to test and refine cost containment strategies, begin to realize health status improvement results (and cost reductions associated with these results) of longer term health improvement strategies (wellness, disease management, etc) Allow the model time to adapt for long-term sustainability while anticipating needing little or no state support after the pilot phase ends for Values Health members with incomes exceeding the MinnesotaCare income threshold. | <p><u>Values Health combines Health Care Home Model with disease mgmt.</u></p> <ul style="list-style-type: none"> Create a Health Care Home structure within the Values Health provider network Enrollees to select a PCP from list of qualified healthcare home providers Use HealthCare Home Match (HCHM) tool by PrimeWest Health Care Home provider compensation at a higher rate for care plans rendered to completion of care plan objectives Health Care Home performance assistance given to providers whose performance is substandard, but if they consistently fail, their affiliation will be discontinued and reimbursement back to usual rate HCH credentialing will follow MN statutes and NCQA guidelines <p><u>Care coordination of medical, mental health, and chemical dependency care:</u></p> <ul style="list-style-type: none"> Co-location of MH professionals in PC clinics for consultation, dx, triage, care Consultation between psychiatry, child psychiatry, physicians, and advanced practice nurses for rapid access for questions and alternatives Collaboration or "shared care" of patient between mental health and primary care—teamwork Care coordination and mgmt via phone, writing, electronic contact, for patients with mental illnesses, substance abuse, ADHD, other common conditions CME to PCP's on common mental illnesses Mental Health screening—PHQ, Vanderbilt for kids Triage & collaborative assessment involving a MH professional assigned to the clinic. Emergency psychiatric appt availability Application of integrated behavioral health model to medical conditions such as diabetes, asthma, COPD, CAD, obesity | <p>Values Health will identify and quantify all the outcomes, costs and savings associated with providing services to uninsured in as many places as possible.</p> <p>Possible evaluation measures may include:</p> <ul style="list-style-type: none"> Changes in MHCP enrollment Provider participation and satisfaction Improvements in screening and education Improvements in early identification & intervention Success in developing care & wellness plans-- objective achievement rate by participant type and service providers Wellness and health care knowledge improvement Preventable hospital admissions Annual cost-benefit analysis of state portion Trending annual health care expenditures by provider and/or service type and by major diagnosis categories Care coordination and service delivery Integration effectiveness (costs and outcomes) Administrative effectiveness and cost tracking Individual health status (short and long-term) Improved quality of provider services Hospital uncompensated care costs Comparing annual costs associated with managing specific chronic diseases against national or state (if available) average health care costs attributable to these chronic disease Work and school absenteeism Member and stakeholder satisfaction Employer participation. |